DoD Healthcare Quality Initiatives Review Panel Report

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Editor's Note:

The reader is advised that within the context of this report the terms TRICARE and Military Health System (MHS) are used synonymously. TRICARE (the MHS) consists of both the direct care system of military hospitals and clinics and the purchased care system of civilian network affiliated and non-network healthcare providers. Networks of civilian providers have been developed and are maintained by managed care support contractors on a regional (multistate) basis.

Within military hospitals and clinics, care is provided by military and civilian healthcare professionals, the latter of whom may be either contract or civil service employees.

The reader is referred to the Glossary for further clarification of acronyms and technical terms.

INTRODUCTION

On behalf of the members of the Department of Defense Healthcare Quality Initiatives Review Panel, I would like to thank the Secretary of Defense and the Assistant Secretary of Defense for Health Affairs for the opportunity to serve on this congressionally chartered Federal Advisory Committee.

For our task, each Panel member brought to bear many years of experience and dedicated service related to healthcare, much of it in or for the federal sector. The diversity of perspectives proved to enhance, rather than to obstruct, our ability to engage with a series of difficult and complex (some egregious) administrative or clinical issues and to make recommendations for corrective initiatives.

It has been a challenging but gratifying 17-month odyssey—challenging because of the mass of material considered and because of the need to understand detail and context in rapidly changing internal and external environments over the past decade. We have also come to realize that woven through several of the initiatives are some discernible themes that deserve emphasis in their own right and that might assist in the future evolution of the DoD TRICARE system.

The effort was gratifying as well—partly because consensus was achieved, but also because of the continuing evidence that, despite adversity, the core values, commitment, and efforts of military healthcare providers remain strong.

On a technical note, the Panel has attempted to achieve a "user-friendly" format as presented in the Table of Contents. Included are an executive summary; a section presenting an overview perspective and four general recommendations; a compendium of all the Panel's conclusions and recommendations; nine chapters, each focused on a specific charter initiative and each presenting the specific conclusions and recommendations of the Panel relevant to that initiative; and, finally, a glossary of terms and acronyms used in the report.

The Panel has opted to provide some selected material as appendices at the end of pertinent chapters. Other general interest items related to the Panel's work are included as Annexes at the end of this volume; however, most of the material accumulated by the Panel through briefings and other review activities has been archived. It is referenced where appropriate in this report, but it has not been included in the bound version because of space limitations.

Abundant thanks are due from all of the Panel members to many individuals who are identified elsewhere in this report but are mentioned here collectively for emphasis: our uniformed tri-Service support staff, our contract support staff, the leadership of the DoD Office of Health Affairs and the TRICARE Management

Activity, and the Surgeons General and their staffs. This massive effort could not have been accomplished without their interest and support!

In addition, to the many, many others who are not specifically identified in this report but who offered us their essential input, field site assistance, inspiring examples, frustrations, and candid critiques, we express our gratitude and profound respect.

Through the support acknowledged above and through its own collective efforts, the Panel believes it has produced a thorough, efficient, balanced, and insightful report as mandated. The Panel believes that this report will be useful in resolving many, though not all, questions that have arisen about the specific DoD healthcare initiatives cited herein. Nevertheless, in some instances there are no simple "answers"—but rather more questions and other options and priorities waiting to be addressed. The Panel hopes that its recommendations will also prove helpful for such considerations and for the future evolution and improvement of the system.

Alfred S. Buck, MD, FACS
Chairman
DoD Healthcare Quality Initiatives Review Panel

EXECUTIVE SUMMARY

The Panel's Charter—Rationale and Tasks

In 1997, the Cox News Service published a series of articles in the *Dayton* (Ohio) *Daily News* written by Russell Carollo and Jeff Nesmith. These articles described incidences of egregious outcomes—administrative and clinical—that had adverse impact on patients. In addition, the articles implied that there was a "double standard" between the military and civilian healthcare sectors, leaving many readers with the impression that the quality of the military healthcare sector was deficient.

In response, the Acting Assistant Secretary of Defense (Health Affairs) (ASD[HA]) developed and reported to Congress 13 proposed actions addressing issues raised in the Cox News Service articles. Subsequently, Congress consolidated these potential actions into nine initiatives as follows:

- Upgrade professional education and training requirements for military physicians and other healthcare providers.
- Establish Centers of Excellence for complicated surgical procedures.
- Make timely and complete reports to the National Practitioner Data Bank (NPDB) and eliminate associated reporting backlogs.
- Ensure that Military Health System (MHS) providers are properly licensed and have appropriate credentials.
- Reestablish the Quality Management Report (QMR) to aid in early identification of compliance problems.
- Improve communication with beneficiaries to provide comprehensive and objective information on the quality of care being provided.
- Strengthen the national quality management program.
- Ensure that all laboratory work meets professional standards.
- Ensure the accuracy of patient data and information.

In Public Law 105-174, section 5, Congress chartered the DoD Healthcare Quality Initiatives Review Panel as a Federal Advisory Committee "to assess whether all reasonable measures have been taken to ensure that the Military Health Services System delivers healthcare services in accordance with consistently high professional standards. The Panel shall specifically assess actions of the Department (of Defense) to accomplish" the objectives of that initiative listed above "and related management actions…."

The Panel was directed "to submit a report to the Secretary (of Defense) setting forth its findings and conclusions, and the reasons therefore, and such recommendations it deems appropriate. The Secretary shall forward the report of the Panel to Congress not later than 15 days after the date on which the Secretary receives it, together with the Secretary's comments on the report."

In addition, Congress provided $4,700,000 "to be available through fiscal year 1999, only for the administrative costs of this panel and for the express purpose of initiating or accelerating any activity identified by the Panel that will improve the quality of healthcare provided by the Military Health Services System." Based on recommendations from the TRICARE Management Activity of the ASD(HA), the Panel approved allocations of $4,350,000 for three specific development or enhancement efforts to be implemented as listed below and described in more detail in the pertinent chapters.

Approach to Tasks

The Panel was constituted in the summer of 1999 with nine members, two alternate members, and staff support that included personnel assigned from the TRICARE Management Activity of ASD(HA) and personnel provided through a contractor, Standard Technology, Inc.

The Panel began its formal work in September 1999. This work was conducted through a series of open public meetings, announced in advance, during which briefings were held, public comment was invited and received, discussions were conducted, and, as requested by the Panel, further clarification, special reviews, and information from a broad spectrum of experts were received and considered. The Panel attended the Annual TRICARE Conference in 2000 and met individually with the Service Surgeons General.

In addition, the Panel conducted site visits in four TRICARE Regions at representative military treatment facilities, a facility shared with the Department of Veterans' Affairs (DVA), and a Uniformed Services Treatment Facility (USTF). These site visits, also publicized and coordinated in advance, involved discussions with facility beneficiaries, professional staff, and commanders. Communication with beneficiaries, the general public, and other interested parties was enhanced through the Panel's Internet Web site, www.hqirp.org/, administered by the contractor.

Through this input, and supported by its discussion, analysis, experience, and accumulated reference material, the Panel has produced for this report a series of conclusions and recommendations. Unanticipated at the beginning was the emergence of core issues so significantly related to many of its charter initiatives that the Panel decided to present them in a separate statement with pertinent recommendations. This material is summarized in the next section and is followed by major recommendations that correspond to the chapters in the text.

Four General Recommendations Related to Core Issues

The Panel wishes to emphasize its finding that most military health professionals of all types are highly dedicated, knowledgeable, productive, and effective—equal to their colleagues in the civilian

sector. Further, based on the Panel's assessment, the regulation, structure, and monitoring of healthcare and its administration within the direct care (military) component of the TRICARE system are dynamic and at least as stringent as those of any healthcare system in America today.

Nevertheless, the unfortunate instances reported in the Cox News Service articles required scrutiny and raised justifiable concerns. Common to these egregious instances were staffing issues (quantity, competency, and continuity) and medical records issues (accuracy, completeness, timeliness, and continuity). To some degree, these ongoing, systemic challenges might be regarded as sentinel aspects of policy development and resource management (acquisition, allocation, and stability). These core issues, so significantly related to many of its charter initiatives, stimulated the Panel to consider and develop four general recommendations in addition to the 44 specific recommendations to improve quality relative to the nine initiatives in the Panel's charter.

- **Implement a Unified Military Medical Command to:**

  a. achieve stability and uniformity of healthcare processes and resource acquisition.

  b. manage an error reduction and safety program based on root cause analysis, system process redesign, responsive resource management, and provider education.

In considering the initiatives and objectives in its charter, the Panel noted instances where the lack of uniform processes across Services hindered the ability of the overall system to aggregate consistent information, analyze it, and achieve stability and comparability with minimal variation. Although a lack of uniform processes does not necessarily result in poor clinical quality, it can hinder the development and administration of a robust Military Health System (MHS) quality management system, and in the extreme it can limit accountability. Additionally, there appears to be difficulty (perhaps inability or unwillingness) in reallocating or transferring resources within a single Service or across Services (not to mention other federal agencies). Intuitively, it would seem likely that such difficulties would lead to adverse cost and process outcomes.

The Panel believes that lack of uniform workload reporting, cost analysis, and resource stability directly affect the ability to assess quality. *While less visible than the adverse outcomes cited in the Cox News Service articles, these factors establish the propensity for adverse outcomes more than any other factors do.* The Panel recognizes this is a complex issue that requires extensive examination.

- **Achieve comparability of oversight and accountability across the TRICARE spectrum—including both the direct care and purchased care components.**

Beneficiaries who use a contractor-established civilian network, or individual providers not in a network, do not necessarily have the same assurances of vigorous scrutiny of credentials and critical review of practice and privileges that their counterparts with access to Military Treatment Facilities can assume. The Panel found, in most instances, that the MHS monitors, oversees, establishes standards, notes and corrects deficiencies, establishes processes, and develops data and reports at its own facilities. However, the MHS is not yet able to extend this direct oversight and influence of process (or congruent proxies thereof) to its civilian networks.

More should be done to ensure comparable standards of quality and value by 1) exploring independent, comprehensive assessments of the contracted networks and their providers; 2) requiring a visible, performance-based process

for the oversight and reappointment of network providers; and 3) using comprehensive, common processes and outcome metrics to support depiction of experience and process improvement across the direct and contracted segments of TRICARE.

- **Expand and refine credentials management for all healthcare professionals in the Military Health System (MHS) to:**

  a. enhance oversight, accountability, and career management (especially education) for such personnel; and

  b. support implementation of and develop experience with a centralized federal interagency credentials repository.

The current focus on privileged provider credentials has not addressed the expanding roles of nurses, pharmacists, technical personnel, other nonprivileged healthcare personnel, and administrators, nor the need for continuous monitoring of education, training, and performance. Although TRICARE has considered some "next steps," it needs to steadily strengthen its assessment and monitoring process for nonprivileged healthcare personnel and ultimately integrate this into a unified and standardized credentials system.

- **Install robust, comprehensive data systems capable of measuring and monitoring quality outcomes, resource utilization, and healthcare costs.**

Inefficiencies in data accrual, management, and analysis significantly restrict measurement of performance, assessment of quality of care outcomes, use of resources, and healthcare costs. Without consistency and integrity in such processes, opportunities to improve quality will continue to be encumbered. Efficient, comprehensive systems are fundamental to achieving excellence in both quality healthcare and administration. At present, development and application of such data systems are incomplete and inconsistent across the TRICARE spectrum.

Recommendations to Address DoD Initiatives

The Panel has developed 44 *specific* recommendations to address the nine health care quality initiatives or objectives in its charter. Described below are all recommendations pertinent to these initiatives (numbered items). A compendium of all of the Panel's conclusions and recommendations follows this section.

- **Upgrade Professional Education and Training Requirements for Military Physicians and Other Healthcare Providers.**

1. Performance expectations for all healthcare providers, military or civilian, should be defined and assessed through an ongoing competency assessment program.

2. The plans of the Services covering compliance with Congress' mandate and Department of Defense (DoD) policy memoranda on General Medical Officers (GMOs) should proceed. The Services must ensure that providers assigned have the clinical skills necessary to care for the population served.

3. Physicians and other healthcare providers working in isolated situations should receive technological and resource support (e.g., decision support tools, manpower, and adequate financial allocation) in addition to consultation and oversight.

4. Appointment and retention criteria, performance expectations, and monitoring should be analogous and comparable for all healthcare providers, whether civilian providers working in our purchased care networks or "direct care" providers.

5. Strategies should be developed to enhance the measurement of performance and the assurance of quality in the "purchased care" sector.

- **Establish Centers of Excellence for Complicated Surgical Procedures.**

1. The current effort to develop a program to designate Centers of Excellence (COEs) within and for the Department of Defense (DoD)/ Military Health System (MHS) should be aggressively pursued. This program will be based on the criteria created in the Centers of Excellence Project.

2. Pilot testing of the COE designation process, criteria, metrics, and organizational evaluation process should be completed for selected sets of Diagnosis Related Groups (DRGs) on an aggressive timetable.

3. A representative forum of significant federal and nonfederal constituencies should evaluate early pilot experience and use the information to facilitate refinement and broader implementation.

4. Essential metrics for clinical and administrative COE program elements should be incorporated into DoD/MHS automation initiatives as experience indicates.

The Panel approved a recommendation from the TRICARE Management Activity to allocate $600,000 of appropriated funds for the development, under contract, of COE criteria.

- **Make Timely and Complete Reports to the National Practitioner Data Bank (NPDB) and Eliminate Associated Reporting Backlogs.**

1. Improve the Department of Defense (DoD) Risk Management Program by using an integrated tri-Service process to address cases, perform analysis, and provide coordination with external agency peer review and the Department of Legal Medicine (DLM)/Armed Forces Institute of Pathology (AFIP).

2. Include Risk Management Program information about actions of significance in the DoD Quality Management Report (QMR).

3. Use risk management experience to develop educational products that healthcare professionals and other participants in healthcare services can use to improve safety and reduce risk.

4. Use common metrics in reporting aggregated and stratified risk management experience to facilitate comparisons and analyses of trends.

5. Modify the DoD Risk Management Program to require a uniform comprehensive process for identification and reporting of practitioners not meeting the standard of care in claims by active duty Service members (Feres-barred cases).

6. Require Managed Care Support Contractors (MCSCs) to develop processes for risk management and error reduction that are analogous to those used in the direct care system.

- **Assure That Military Health System Providers Are Properly Licensed and Have Appropriate Credentials.**

1. The current direct care system licensure policy promulgated by Department of Defense (DoD) Directive should be continued within the context of a dynamic, increasingly performance-data based quality management program.

2. The Assistant Secretary of Defense for Health Affairs (OASD(HA)) must continue to monitor state legislative initiatives on licensure of healthcare professionals and work with national

entities to achieve uniformity of requirements, processes, assessment methodologies and results.

3. The Centralized Credentials Quality Assurance System (CCQAS), the automation platform for credentials management in the direct care system, should be aggressively refined to achieve the following:

    a. Interface with other federal agency platforms to facilitate functions such as reserve mobilization, comparable performance assessment, and mission-directed rapid reassignment among federal military and nonmilitary clinical facilities;

    b. Include meaningful, relevant, supportive clinical data;

    c. Facilitate timely individual updates for essential data or information fields, such as medical license renewal and continuing medical education content and credit hours; and

    d. Offer programmed and ad hoc capabilities for generating reports so that various levels of oversight and management can better manage personnel.

4. CCQAS should be tested within a TRICARE region to facilitate better and more comparable credentials review and appointment procedures between the Managed Care Support Contract (MCSC) system and the direct care system.

The Panel approved a recommendation from the TRICARE Management Activity to allocate $750,000 of appropriated funds to further develop and refine the CCQAS platform.

- **Reestablish the Quality Management Report (QMR) to Aid in Early Identification of Compliance Problems.**

1. Reestablish and improve the Quality Management Report as a:

    a. Comprehensive information product for communicating with and educating leadership within Congress, the office of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]), TRICARE Management Activity (TMA), the Services, and the Military Treatment Facilities (MTFs) on the status of quality in the Military Health System (MHS);

    b. Framework to position and bridge essential components of the proactive MHS Quality Management Program; and

    c. Vehicle to facilitate meaningful, specific comparisons among the Services, the federal agencies, and the civilian healthcare sector, especially in the risk management and patient safety arena.

2. Continue to refine the TRICARE Operations Performance Statement (TOPS) program to achieve better automated data support, better data utility for the operational levels of MTF and Regional Lead Agents (senior regional TRICARE administrative function) improved data quality, and better reflection of personnel resources.

3. Promulgate a definition of “quality” concerning MHS and TRICARE healthcare and related services that can be used to identify and position data and automation support initiatives in the future. Incorporate the definition into DoD Directive 6025.13, “Clinical Quality Management Program in the Military Healthcare System.”

- **Improve Communication with Beneficiaries to Provide Comprehensive and Objective Information on the Quality of Care Being Provided.**

1. Maintain and continue to improve the Military Treatment Facility (MTF) report cards so that they provide meaningful information to beneficiaries. Further, through communication with beneficiaries, continue to identify those markers of quality of care that the beneficiaries determine should be measured on the MTF report card.

2. Maintain and continue to improve the provider directories so that they furnish meaningful information to beneficiaries.

3. Maintain and continue to improve the Healthcare Consumer Councils (HCCs) so that they provide a forum for a meaningful dialogue to connect beneficiaries with both the providers and the administrators of their healthcare. Tracking and resolution of identified issues should be a significant agenda item.

4. Make the benefit and benefit administration uniform across the TRICARE spectrum, including the direct care and purchased care components.

5. Continue to develop initiatives to improve communication with beneficiaries and to enhance their education on health quality issues.

- **Strengthen the National Quality Management Program.**

1. Update Department of Defense (DoD) Directive 6025.13, "Clinical Quality Management in the Military Health Services System" and include a definition of quality for TRICARE clinical healthcare and related services to orient current and future measurement initiatives.

2. Implement a uniform resourcing methodology to allow integration of resource management data and analyses into quality management processes.

3. Incorporate the National Quality Management Program (NQMP) external review of healthcare products into the audit and feedback process for improvement of healthcare and related services across the TRICARE spectrum including the direct care and purchased care components.

4. Continue to use an external peer review agency for malpractice case reviews.

5. Support and expand interagency collaboration in forums such as the Quality Interagency Information Coordination Task Force (QuIC) to leverage knowledge and resources for improving healthcare quality within the federal system and across the nation.

- **Ensure That All Laboratory Work Meets Professional Standards.**

1. Consolidate cytopathology centers across the Military Health System (MHS).

2. Develop supportive "production based" (reportable test) staffing models to ensure uniform adequacy of staff levels and ongoing training across all clinical laboratory disciplines.

3. Use the Centralized Credentials Quality Assurance System (CCQAS) to enhance the management of credentials of all laboratory professionals, whether officer, enlisted, contract, or civil service.

4. Require that clinical laboratory personnel hold and maintain qualifications analogous to those of their colleagues in the civilian sector.

5. Require that military personnel should meet federal standards; civil service and civilian contract personnel should meet the higher of federal or local jurisdictional standards.

- **Ensure the Accuracy of Patient Data and Information.**

1. Move forward rapidly with development and implementation of the Composite Health Care System, Second Implementation (CHCS II) to provide more comprehensive, efficient electronic medical record support for all Department of Defenses (DoD) beneficiaries.

2. Continue as planned to enhance and ultimately absorb CHCS I into CHCS II through phased implementation of CHCS II.

3. Ensure that appropriate analytical and ad hoc reporting capabilities are available for CHCS II data to provide pertinent assessment information for management at all levels within and across the military Services and for all healthcare settings of the military.

4. Ensure that a longitudinal electronic health record exists for active duty military personnel, maintained through a global capability to link pertinent information databases available for peacetime and deployed operations.

5. Participate actively in national and federal interagency policy and data standards development activities with organizations such as the National Committee on Vital and Health Statistics.

6. Plan, program, budget, and fully fund business process reengineering resource requirements to facilitate full implementation of the MHS Optimization Plan and Force Health Protection.

7. Establish strategic goals to progressively enhance "connectivity" with Computerized Patient Records (CPRs) generated by managed care network providers and other providers working on behalf of TRICARE, not in the direct care system. Such integration, as feasible, should support common (uniform) data quality standards, data aggregation, audit, and robust analytical and report generation capabilities.

The Panel approved a recommendation from the TRICARE Management Activity to allocate $3,000,000 to develop and pilot test clinical decision support enhancements compatible with CHCS II.

Next Steps

The Panel believes it has achieved a thorough, efficient, balanced, and insightful report as mandated. It believes that this report will be useful in resolving many, though not all, questions that have arisen about the specific DoD healthcare initiatives cited herein.

Nevertheless, in some instances there are no simple answers—but rather more questions and other options and priorities waiting to be addressed. The Panel hopes that its recommendations will also prove helpful for such considerations and for the future evolution and improvement of the system.

Implementation of these recommendations will require additional resources. The Panel recommends that, with appropriate coordination and setting of priorities, adequate funding be made available.

The Panel members, individually or collectively, stand ready to assist in whatever fashion is deemed best to ensure an effective and efficient delivery of the Panel's recommendations and to continue with their ongoing engagement.

OVERVIEW PERSPECTIVE AND GENERAL RECOMMENDATIONS

Panel General Recommendations

1. Implement a Unified Military Medical Command to:

    a. achieve stability and uniformity of healthcare processes and resource acquisition, and

    b. manage an error reduction and safety program based on root cause analysis, system process redesign, responsive resource management, and provider education.

2. Achieve comparability of oversight and accountability across the TRICARE spectrum—including both the direct care and purchased care components.

3. Expand and refine credentials management for all healthcare professionals in the Military Health System (MHS) to:

    a. enhance oversight, accountability, and career management (especially education) for such personnel; and

    b. support implementation of and develop experience with a centralized, federal interagency credentials repository.

4. Install robust, comprehensive data systems capable of measuring and monitoring quality outcomes, resource utilization, and healthcare costs.

Introduction

In this document, the Healthcare Quality Initiatives Review Panel has addressed with specific recommendations the initiatives identified in its charter; these initiatives had been formulated on the basis of statements made in the Cox News Service articles. The Panel sensed early that woven through the Cox articles were issues that would be better addressed with global recommendations. Further, the Panel was encouraged by the leadership of the DoD to explore more comprehensively any aspects of the issues and initiatives that the Panel thought might offer helpful perspective on military healthcare.

Panel Perspective

The Cox News Service articles were based on specific, egregious instances of adverse clinical outcomes or failures of professional management. The articles implied that there was a "double standard" between the military and civilian health sectors, leaving many readers with the impression that the military sector was deficient.

Based on its hearings, briefings, reviews, site visits, experience, and discussion, the Panel believes that such an implication is misleading and damaging. Rather, the Panel wishes to emphasize its finding that most military health professionals of all types are highly dedicated, knowledgeable, productive, and effective—equal to their colleagues in the civilian sector. Further, the Panel's assessment is that the regulation, structure, and monitoring of healthcare and its administration within the direct care (military) component of the TRICARE system are dynamic and at least as stringent as any healthcare system in America today.

Nevertheless, the unfortunate instances reported in the Cox News Service articles do require scrutiny and raise justifiable concerns. Common to these egregious instances were staffing issues (quantity, competency, and continuity) and medical records issues (accuracy, completeness, timeliness, and continuity). To some degree, these ongoing, systemic challenges might be regarded as sentinel aspects of policy development and resource management (acquisition, allocation, and stability).

Below are listed four recommendations that the Panel views as important to improving quality.

General Recommendation One:

Implement a Unified Military Medical Command.

The Cox News Service articles often cited a specific military medical facility, and many readers could discern which of the military Services it belonged to. However, the critiques in these articles and those by other authors on other occasions set forth an expectation that *all* military treatment facilities—regardless of Service identity—would adhere to the *same* highest standards of care and would achieve results that compared favorably with those in the civilian sector. In other words, the quality of care from all Services was expected to be exemplary and consistent with the overall performance expectations of the Armed Forces of the United States; there was no expectation of differences among Services. The Panel shares this perspective or expectation, which was often assumed or expressed in the communications it has received and was often referred to in the presentations and discussions in which it has participated. In this spirit, the following is presented.

In considering the initiatives in its charter, the Panel has noted instances where the lack of uniform processes across Services has hindered the ability of the overall system to aggregate consistent information, analyze it, and achieve stability and comparability with minimal variation. Although a lack of uniform processes does not necessarily result in poor clinical quality, it can hinder the development and administration of a robust Military Health System (MHS) quality management system, and in the extreme it can limit accountability. Additionally, there appears to be difficulty (perhaps inability or unwillingness) in reallocating or transferring resources within a single Service or across Services (not to mention other federal agencies). Intuitively, it would seem likely that such difficulties would lead to adverse cost and process outcomes.

The Panel has been told that some form of unified command of military medical forces has been discussed for more than 50 years. A recommendation for unification of Military Medical Services, in the Defense Management Report Decision 970 on Management of Defense

Health Care written in the late 1980s, was declined. Instead, the decision was made to use a new Defense Health Program (DHP), the annual medical budget of the Department of Defense (DoD), to be administered through the Assistant Secretary of Defense for Health Affairs (ASD[HA]) and later through TRICARE Management Activity (TMA). The intent was to create a type of "Defense Health Agency" by fiscal fiat and thus to bring unity of policy, process, and direction across the individual Service medical systems. The Panel understands that the administration of the DHP via OASD(HA) has been less successful in producing integration and unity than was originally intended.

a. Achieve stability and uniformity of healthcare processes and resource acquisition.

The Panel has noted the General Accounting Office (GAO) report, GAO/HEHS-00-10, published in November 1999 and titled "DEFENSE HEALTH CARE: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care." The report highlighted the redundancy and overlap of military medical services in the National Capital Region and extrapolated some findings to the larger tri-Service system. This redundancy and lack of coordination, the GAO found, arises largely from the autonomy of the individual Service medical systems, their lack of coordination of vision and goals, and their inter-Service competition rather than collaboration.

A telling statement in this GAO report, especially pertinent to this Panel's charter and review, is the following quote from page 12:

> Accurate, comparable MTF [Military Treatment Facility] workload data are needed for performance measurement, cost-effectiveness assessments, and alternative care delivery evaluations. Such data include numbers and cost of outpatient clinical visits, inpatient admissions, and average length of stay. But each service defines workload differently, and as basic an element as a clinic visit is not counted the same. Also, the cost and workload data captured in DoD's information systems is neither accurately reported nor recorded.

(Similar themes, focused on differences in budgeting processes, were presented in a related GAO report, GAO/HEHS-00-52, published in May 2000 and titled "VA [Veterans Affairs] and Defense Health Care: Evolving Systems Require Rethinking of Resource Sharing Strategies.")

The Panel believes that the deficiencies quoted above, while surely less visible than the adverse outcomes cited in the Cox News Service articles, establish the propensity for adverse outcomes more than any other factors do.

In this context, the Panel has two general concerns, both related to one or more of the DoD healthcare quality initiatives and to the issue of a Unified Military Medical Command. One is the need for a system-wide program to improve processes that affect patient safety. The other is the need for uniformity and stability in the resourcing of elements of quality healthcare among the Services.

b. Manage an error reduction and safety program based on root cause analysis, system process redesign, responsive resource management, and provider education.

The committee reviewed the Report of the President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry (1998), the Institute of Medicine (IOM) report on Medical Errors and Patient Safety (1999), and the Quality Interagency Coordinating Task Force (QuIC) response to it mandated by the President of the United States.

The Panel applauds the IOM for its courageous report and for its statement that medical errors most

often result from system problems that are amenable to system (root cause) analysis and correction through process redesign and education. These key activities, to be of optimal effect, require dynamic, responsive resource management.

The IOM makes clear, in the full text of its report, that the medical system needs to borrow a page from other industries that have understood the need to look at accidents and errors from the perspective of process flaws and to develop process solutions to correct the problems—the airline industry is one such example.

The MHS has already implemented, or has plans to implement, several of the recommendations in the reports cited above, where appropriate and applicable. In addition, a set of difficult issues—such as reporting methodology, enterprise liability, and tort reform—will need continued attention. Nevertheless, the essential emphasis on process and system performance, assessment, and refinement, linked directly to resource management, leads the Panel to conclude that an effective program of error reduction and patient safety for military healthcare would be better achieved within a Unified Military Medical Command.

In addition, common metrics that meaningfully depict experience across the military healthcare system and its sites of care are urgently needed (see the GAO report quote above). The Panel understands that important efforts toward this goal are under way, yet significant components will need intensive coordination, setting of priorities, and implementation. (Some of these are presented in more detail in subsequent chapters, especially Chapter IX.)

Assuming that a responsive infrastructure is achieved, the system must address specific policy and operational requirements, including resolution of data quality issues, methodology of analyses, comparisons within and outside of the TRICARE healthcare system, evidence-based (statistically sound) identification of best practices that include resource or value determinations, report generation to various constituencies, and so forth. For emphasis, such policy and operational requirements are basic to effective reduction of errors, improvement of process, and optimal balance of resources with missions.

The needed capabilities, emphasized in more detail in the major reports cited in this section, establish the ultimate goals of stability of healthcare process and stability of resource acquisition, which are central to error reduction and improved quality management. As advanced in the Cox News Service articles, the continuity requirement that is basic to successful staff teamwork and to the flow of clinical information needs a stable platform or framework for administration, policy development, oversight, accountability, and resource management. Stability in this context can provide greater dynamism of action, change, and improvement.

The Panel acknowledges that many other issues need to be resolved before the potential benefit achievable from a Unified Military Medical Command can be fully evaluated. The Panel believes, however, that the issues and recommendations presented above provide a helpful subset of functions to be considered for the charter of such an entity or of any other alternative future military healthcare command structure.

General Recommendation Two:

Achieve comparability of oversight and accountability across the TRICARE spectrum, including both the direct care and purchased care components.

As the active duty military medical force has shrunk in proportion to overall resizing of the Armed Forces, an increased percentage of military healthcare beneficiaries have been required to seek medical care from civilian networks established by

MHS Managed Care Support Contractors (MCSCs), provided, in turn, through TRICARE. Beneficiaries who use a contractor-established civilian network, or individual providers not in a network, do not necessarily have the same assurances of vigorous scrutiny of credentials and critical review of practice and privileges that their counterparts with access to Military Treatment Facilities can assume.

The Panel found, as a consistent theme, that in its own facilities, in most instances, the MHS monitors, oversees, establishes standards, notes and corrects deficiencies, establishes processes, and develops data and reports. It is not yet able to extend this direct oversight and influence of process (or congruent proxies thereof) to its civilian networks. The result is a two-tiered system of oversight, quality management, and accountability within the MHS. While no doubt many of the network institutions and providers successfully meet high standards, the MHS has no way of ensuring consistency and proven comparability between the "direct care" provided within military facilities and the care provided by civilian facilities and providers within its networks. Although this is not exclusively an MHS problem, the Panel believes that more should be done to ensure comparable standards of quality and value by:

- exploring independent, comprehensive assessments of the contracted networks and their providers;
- requiring a visible, performance-based process for the oversight and reappointment of network providers; and
- using comprehensive, common processes and outcome metrics to support depiction of experience and process improvement across the direct and contracted segments of TRICARE.

General Recommendation Three:

Expand and refine credentials management for all healthcare professionals in the Military Health System (MHS) to:

a. enhance oversight, accountability, and career management (especially education) for such personnel; and

b. support implementation of and develop experience with a centralized, federal interagency credentials repository.

The management of credentials for military physicians, dentists, and other privileged providers has been intensively addressed thus far through the Centralized Credentials Quality Assurance System (CCQAS). The Panel finds that verification and monitoring of these military healthcare providers' credentials (licensure, continuing education, training, board certification, etc.) is very good, and at the facility level it compares favorably with the civilian sector system, based on assessed compliance with credentialling standards set forth by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). (In 1999, 86.6 percent of DoD facilities surveyed by JCAHO were in substantial or significant compliance with these standards, compared with 63.2 percent for the civilian sector.) Further, the support provided by CCQAS for credentials management has facilitated the important processes of staff appointment, privileging (authorization of a specific, facility-dependent scope of practice), reappointment (reauthorization) based on demonstrated performance, and field deployment or rapid transfers of physician and dental officers in mobilization for troop and other mission support.

The current focus on privileged provider credentials has not addressed the expanding roles of nurses, pharmacists, technical personnel, other nonprivileged healthcare personnel, and

administrators, nor the need for monitoring education, training, and performance. Although TRICARE has considered some "next steps," it needs to steadily strengthen its assessment and monitoring process for nonprivileged healthcare personnel and ultimately integrate this into a unified and standardized credentials system.

The policy of state licensing of military providers offers considerable (but not complete) protection from fraud in the accessioning process of medical personnel, and does support a basic platform for competency assessment. However, as important as the licensing requirement is, it provides a basic and rather static level of credentials scrutiny. Although state licensure was given prominent focus in the Cox News Service articles, the Panel believes that state licensure alone has not stood and cannot stand as a guarantor of healthcare provider quality (see Chapter IV).

Further, the risks of using state licensure as a guarantee of competence for healthcare professionals can be heightened in such use by a federal system (e.g., within the TRICARE contracted care systems of the MHS) because of differences in licensing requirements from state to state and differences in the robustness of states' oversight for their licensed healthcare providers.

Although the Panel understands this problem of variation with licensure to be a national issue not limited to the military, it believes that experience gained through implementation of the recommendations in Chapter IV can significantly enhance the dialogue about this issue in various forums—especially the analogous efforts by the Federation of State Medical Boards and the National Council for State Boards of Nursing. (Related issues beyond the scope of this Panel but identified in its discussion include telemedicine, disaster mobilization, and standard-of-care determinations.)

In addition to the recommendations cited above, the Panel believes that the MHS should continue to coordinate its efforts to expand use of CCQAS with the similar Veterans Administration Professional Review Program (VETPRO) effort by the Departments of Veterans Affairs (DVA) and Health and Human Services, and to work with others (e.g., the National Credentialling Forum) through the Federal Inter-Agency Credentialling Initiative. Important benefits in credentials management can be derived from the integration or "linkability" of CCQAS and VETPRO—for example, for reservists. This major opportunity for interagency collaboration should perhaps be a focus for the DoD/DVA Executive Committee.

Key goals should be consistent national credentials standards; automated, linkable repositories of verified data with appropriate security and privacy safeguards; and consistent national standards for formatting and reporting credentials data elements and related information for defined purposes. Taking experience with such efforts into account would likely be beneficial when considering other strategic options, such as defined linkage among national Health Care Financing Administration provider numbers, federal and state Drug Enforcement Administration numbers, the National Practitioner Data Bank, and the Health Information Portability and Protection Data Bank.

General Recommendation Four:

Install robust, comprehensive data systems capable of measuring and monitoring quality outcomes, resource utilization, and healthcare costs.

A persistent fundamental theme that permeates each chapter of this report—and specifically relates to the other important general recommendations discussed above—is a range of insufficiencies in the manner in which the utility of important data relating to all aspects of performance across the

TRICARE spectrum is assured. Confounding and competing data systems of varying maturity, as well as lack of integration, standardization and connectivity between such systems, suggests that long-term unified planning has been inefficient.

Inefficiencies in data accrual, management and analysis significantly restrict measurement of performance, assessment of quality of care outcomes, use of resources, and healthcare costs. Without consistency and integrity in such processes, opportunities to improve quality will continue to be encumbered. Efficient, comprehensive systems are fundamental to achieving excellence in both quality healthcare and administration. At present, development and application of such data systems is incomplete and inconsistent across the TRICARE spectrum.

Panel General Recommendations

1. Implement a Unified Military Medical Command to:

    a. achieve stability and uniformity of healthcare processes and resource acquisition, and

    b. manage an error reduction and safety program based on root cause analysis, system process redesign, responsive resource management, and provider education.

2. Achieve comparability of oversight and accountability across the TRICARE spectrum—including both the direct care and purchased care components.

3. Expand and refine credentials management for all healthcare professionals in the Military Health System (MHS) to:

    a. enhance oversight, accountability, and career management (especially education) for such personnel; and

    b. support implementation of and develop experience with a centralized, federal interagency credentials repository.

4. Install robust, comprehensive data systems capable of measuring and monitoring quality outcomes, resource utilization, and healthcare costs.

COMPENDIUM OF PANEL CONCLUSIONS AND RECOMMENDATIONS

General Recommendations

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Chapter I
Upgrade Professional Education and Training Requirements for Military Physicians and Other Healthcare Providers

Panel Conclusions

1. A dynamic competency assessment program is essential to coordinate the information needed to align providers with operational needs and to develop training requirements for all military healthcare providers.

2. The Panel recognizes that DoD and the MHS have initiated rational approaches to minimize the number of GMOs assigned and to optimize the oversight and performance of GMOs that are required.

3. Assignment criteria, performance expectations, and monitoring of contract physicians working within military treatment facilities have been enhanced and are equivalent to those affecting their military counterparts.

4. Performance expectations have been appropriately enhanced to guide retention of physicians.

Panel Recommendations

1. Performance expectations for all healthcare providers, military or civilian, should be defined and assessed through an ongoing competency assessment program.

2. The plans of the Services covering compliance with Congress's mandate and Department of Defense (DoD) policy memoranda on General Medical Officers (GMOs) should proceed. The Services must ensure that providers assigned have the clinical skills necessary to care for the population served.

3. Physicians and other healthcare providers working in isolated situations should receive technological and resource support (e.g., decision support tools, manpower, and adequate financial allocation) in addition to consultation and oversight.

4. Appointment and retention criteria, performance expectations, and monitoring should be analogous and comparable for all healthcare providers, whether civilian providers in our purchased care networks or "direct care" providers.

5. Strategies should be developed to enhance the measurement of performance and the assurance of quality in the "purchased care" sector.

Chapter II
Establish Centers of Excellence for Complicated Surgical Procedures

Panel Conclusions

1. The concept of designating facilities, military or civilian, as COEs to provide selected specialized, complex treatments to DoD/MHS beneficiaries is appealing and offers great potential benefit.

2. To date, the DoD/MHS (and the nation) have lacked an accepted process to designate such facilities through evidence-based criteria, consensus-based criteria, utilization evidence, and supportive metrics; a periodic mechanism for evaluation has also been lacking.

3. Further development and testing of this COE approach offers the potential for establishment of a defensible standard and will enhance clinical quality and accountability.

4. Additional benefits that may also be derived and related to this development include:

a. Options for "tri-Service" assignments of active duty military specialist personnel;

b. Rational, experience-based treatment counseling and education for patients, staff, and decision makers;

c. Use of interagency sharing capabilities and of civilian academic medical centers; and

d. Sizing and maintenance of appropriate specialty resources, including personnel, within active duty and reserve military medical components.

Panel Recommendations

1. The current effort to develop a program to designate Centers of Excellence (COEs) within and for the Department of Defense (DoD)/ Military Health System (MHS) should be aggressively pursued. This program will be based on the criteria created in the Center of Excellence Project.

2. Pilot testing of the COE designation process, criteria, metrics, and organizational evaluation process should be completed for selected sets of Diagnosis Related Groups (DRGs) on an aggressive timetable.

3. A representative forum of significant federal and nonfederal constituencies should evaluate early pilot experience and use the information to facilitate refinement and broader implementation.

4. Essential metrics for clinical and administrative COE program elements should be incorporated into DoD/MHS automation initiatives as experience indicates.

Chapter III
Make Timely and Complete Reports to the National Practitioner Data Bank (NPDB) and Eliminate Associated Backlogs

Panel Conclusions

1. The initiatives taken by OASD(HA)/TMA and the Services are well considered and show promise for the following:

   - Enhancing the accuracy and timeliness of reporting to the NPDB,
   - Reducing malpractice case backlogs,
   - Creating a forum for monitoring the risk management process, and
   - Enhancing risk reduction and prevention strategies in the direct care system.

2. A lack of ability and data to make basic, ongoing comparisons persists among the Services; among the DoD, Department of Veterans Affairs, and other federal agencies; and between the military and civilian sectors using risk management data.

3. The MTFs, the Services, and OASD(HA)/TMA have failed to make uniform and sustained efforts to use the results of the risk management process for system improvement across Services at all appropriate levels.

4. Alignment of personnel and other resources to improve safety (risk reduction and prevention) should be periodically examined and apportioned to enhance efficiencies, data generation, and analyses (especially comparative experience among the Services, other agencies, and the civilian sector).

5. Risk management educational initiatives should be performance-based; they should include patients, providers, and contractors; and they should anticipate needs for redesign and timely implementation of process. Such initiatives should be evaluated to assess their impact.

6. The absence of a uniform, mandated evaluation and reporting process for practitioners identified as not meeting the standard of care in Feres-barred cases is a serious deficiency of the risk management program.

7. The lack of data about MCSC risk management experience is a serious flaw that can defeat comprehensive system analysis, improvement, and resource alignment.

Panel Recommendations

1. Improve the Department of Defense (DoD) Risk Management Program by using an integrated tri-Service process to address cases, perform analysis, and provide coordination with external agency peer review and the Department of Legal Medicine (DLM)/Armed Forces Institute of Pathology (AFIP). (See Chapter V.)

2. Include Risk Management Program information about actions of significance in the DoD Quality Management Report (QMR). (See Chapter V.)

3. Use risk management experience to develop educational products that healthcare professionals and other participants in healthcare services can use to improve safety and reduce risk.

4. Use common metrics in reporting aggregated and stratified risk management experience to facilitate comparisons and analyses of trends.

5. Modify the DoD Risk Management Program to require a uniform comprehensive process for identification and reporting of practitioners not meeting the standard of care in claims by active duty Service members (Feres-barred cases).

6. Require Managed Care Support Contractors (MCSCs) to develop processes for risk management and error reduction that are analogous to those used in the direct care system.

Chapter IV
Assure That Military Health System Providers Are Properly Licensed and Have Appropriate Credentials

Panel Conclusions

1. The Cox News Service articles that focused on a special Oklahoma medical license for military physicians did identify a valid deficiency in implementation of policy involving a small subset of military physicians.

2. Once the deficiency was understood, the response of the DoD and the Services to these articles was appropriate, addressing and managing the physicians involved, confirming the licensure status of all physicians, and conducting a thorough review of policy and related process.

3. The Panel understands that there is still great variation among requirements and processes implemented by states to control the issuance and renewal of physician licenses, although some convergence and improvement have been noted. Possession of a state license, while essential, cannot alone fully provide the protections that a dynamic quality management program, as promulgated by DoD policy, does provide.

4. The direct care system's policies and processes for managing physician credentials and

privileging, and for enabling their accountability and providing oversight, are at least as stringent as those used for their civilian counterparts.

5. The robust quality management program of the future must evolve an automated capability, including performance data, to support processes and decisions related to credentials management; competency assessment; and staff appointments, reappointments, and privileging for all appropriate healthcare professionals.

Panel Recommendations

1. The current direct care system licensure policy promulgated by Department of Defense (DoD) directive should be continued within the context of a dynamic quality management program increasingly based on performance data.

2. The Assistant Secretary of Defense for Health Affairs (ASD[HA]) must continue to monitor state legislative initiatives on licensure of healthcare professionals and work with national entities to achieve uniformity of requirements, processes, assessment methodologies, and results.

3. The Centralized Credentials Quality Assurance System (CCQAS), the automation platform for credentials management in the direct care system, should be aggressively refined to achieve the following:

    a. Interface with other federal agency platforms to facilitate functions such as reserve mobilization, comparable performance assessment, and mission-directed rapid reassignment among federal military and nonmilitary clinical facilities;

    b. Include meaningful, relevant, supportive clinical data;

    c. Facilitate timely individual updates for essential data or information fields, such as medical license renewal and continuing medical education content and credit hours; and

    d. Offer programmed and ad hoc capabilities for generating reports so that various levels of oversight and management can better manage personnel.

4. CCQAS should be tested within a TRICARE region to facilitate better and more comparable credentials review and appointment procedures between the Managed Care Support Contract (MCSC) system and the direct care system.

Chapter V
Reestablish the Quality Management Report (QMR) to Aid in Early Identification of Compliance Problems

Panel Conclusions

1. The QMR provides essential information basic to depiction and assessment of MHS quality not now available from data-based automated programs.

2. TOPS does not address operational support at MTF or TRICARE regional levels, data quality issues, or functional resource dependencies.

3. A definition of “quality” for MHS clinical healthcare and related services would serve as a useful yardstick for positioning or assessing automation initiatives, analyses, and reports in the future.

Panel Recommendations

1. Reestablish and improve the Quality Management Report (QMR) as a:

- Comprehensive information product for communicating with and educating leadership within Congress, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]), TRICARE Management Activity (TMA), the Services, and the Military Treatment Facilities (MTFs) on the status of quality in the Military Health System (MHS);

- Framework to position and bridge essential components of the proactive MHS Quality Management Program; and

- Vehicle to facilitate meaningful, specific comparisons among the Services, the federal agencies, and the civilian healthcare sector, especially in the risk management and patient safety arena.

2. Continue to refine the TRICARE Operations Performance Statement (TOPS) program to achieve better automated data support, better data utility for the operational levels of MTF and Regional Lead Agents (senior regional TRICARE administrative function), improved data quality, and better reflection of personnel resources.

3. Promulgate a definition of "quality" concerning MHS and TRICARE healthcare and related services that can be used to identify and position data and automation support initiatives in the future. Incorporate the definition into DoD Directive 6025.13, "Clinical Quality Management Program in the Military Healthcare System."

Chapter VI
Improve Communication with Beneficiaries to Provide Comprehensive and Objective Information on the Quality of Care Being Provided

Panel Conclusions

1. Site visits and other Panel considerations indicate that MTFs are displaying report cards that include the mandatory four elements.

2. Most MTFs have developed and maintain Provider Directories and are working to improve future editions. Improvements are focused on the manner or medium in which the information is made available to the beneficiary. Cost considerations and ease of updating the material have influenced many of the MTFs to develop an electronic record that is accessed at hospital-based computer terminals, instead of printing multiple hard-copy volumes, which are subject to vandalism and theft.

3. Although each is unique in make-up, organizational style, and interest for the beneficiaries, most MTFs have a consistent and regularly scheduled program that enables the beneficiaries to meet with the MTF Commander as well as the MTF staff members.

4. To beneficiaries, the issue of quality of healthcare cannot be separated from a discussion of access and the robustness and uniformity of healthcare benefits.

5. The frequent, ongoing changes in the organizational structure of the MHS and the TRICARE benefit are creating a communication and educational burden for both beneficiaries and providers.

Panel Recommendations

1. Maintain and continue to improve the Military Treatment Facility (MTF) report cards so that they provide meaningful information to beneficiaries. Further, through communications with beneficiaries, continue to identify those markers of quality of care that the beneficiaries determine should be measured on the MTF report card.

2. Maintain and continue to improve the provider directories so that they furnish meaningful information to beneficiaries.

3. Maintain and continue to improve the Healthcare Consumer Councils (HCCs) so that they provide a forum for a meaningful dialogue to connect beneficiaries with both the providers and the administrators of their healthcare. Tracking and resolution of identified issues should be a significant agenda item.

4. Make the benefit and benefit administration uniform across the TRICARE spectrum, including the direct care and purchased care components.

5. Continue to develop initiatives to improve communication with beneficiaries and to enhance their education on healthcare quality issues.

Chapter VII
Strengthen the National Quality Management Program

Panel Conclusions

1. The NQMP is essential for providing the framework and structure for quality management within the direct care system.

2. Establishment of tri-Service committees, such as the SAP and the OSC, and of an educational program to promote use of information from Special Studies and performance measures (HEDIS, ORYX™, CPGs) for clinical performance improvement are appropriate steps toward improving the NQMP and quality of care across the direct care system.

3. The absence of a standard resourcing (e.g., financing, staffing, patient-level cost accounting) methodology across Services for clinical care and services inhibits quality and utilization management.

4. Addition of the external peer review agency to the malpractice case review process enhances objective review of malpractice cases. (However, initial experience has been that it increased the cost and slowed the process.)

5. Combined interagency efforts such as the DoD/VA CPG Work Group and the Quality Interagency Coordination Task Force help to achieve common initiatives in the pursuit of healthcare quality.

Panel Recommendations

1. Update Department of Defense (DoD) Directive 6025.13, "Clinical Quality Management in the Military Health Services System," and include a definition of quality for TRICARE clinical healthcare and related services to orient current and future measurement initiatives.

2. Implement a uniform resourcing methodology to allow integration of resource management data and analyses into quality management processes.

3. Incorporate the National Quality Management Program (NQMP) external review of healthcare products into the audit and feedback process for improvement of healthcare and related services across the TRICARE spectrum.

4. Continue to use an external peer review agency for malpractice case reviews.

5. Support and expand interagency collaboration in forums such as the Quality Interagency Coordination Task Force (QuIC) to leverage knowledge and resources for improving healthcare quality within the federal system and across the nation.

Chapter VIII
Ensure That All Laboratory Work Meets Professional Standards

Panel Conclusions

1. The allegation that military clinical laboratories, based on their exemption from CLIA requirements, meet a lesser standard than civilian ones is misleading, as is any derived implication that military laboratory services were, or are, therefore inferior when compared with analogous civilian ones.

2. MHS MTFs provide services with oversight requirements that are at least as stringent as those in the civilian sector clinical laboratories.

3. Efforts to integrate clinical workload, resource allocation, and staffing to support stability of operations and training with a comparable (uniform) tri-Service methodology are commendable, but they need to be more comprehensive, more vigorously implemented, and fully resourced.

4. Management of credentials for laboratory professionals, especially in situations where licensing or certification are not state or federal requirements, could be improved.

Panel Recommendations

1. Consolidate cytopathology centers across the Military Health System (MHS).

2. Develop supportive "production-based" (reportable test) staffing models to ensure uniform adequacy of staff levels and ongoing training across all clinical laboratory disciplines.

3. Use the Centralized Credentials Quality Assurance System (CCQAS) to enhance the management of credentials of all laboratory professionals, whether officer, enlisted, contract, or civil service.

4. Require that clinical laboratory personnel hold and maintain qualifications analogous to those of their colleagues in the civilian sector.

5. Require that military personnel should meet federal standards; civil service and civilian contract personnel should meet the higher of Federal or local jurisdictional standards.

Chapter IX
Ensure the Accuracy of Patient Data and Information

Panel Conclusions

1. Medical record deficiencies increase the risk of errors and undesired outcomes. These factors were appropriately criticized in the Cox News Service articles.

2. The direct care system is on schedule to acquire and implement a useful, system-wide, electronic patient record that, when fully implemented, will improve accuracy, completeness, timely availability, and continuity over time.

3. In a time of massive change in the environment of healthcare, the MHS is challenged to actively participate in associated policy and standards development in various forums relating to further development and implementation of an electronic medical record.

4. Directive policy is required to re-engineer business processes within the MHS to facilitate integrated analysis and benefits potentially available from use of electronic records (e.g., resource acquisition and justification, utilization, clinical encounters, outcomes, and health status).

5. Use of electronic medical records supporting "connectivity" and appropriate data and clinical information sharing and analysis is not occurring with MCSCs.

Panel Recommendations

1. Move forward rapidly with development and implementation of the Composite Health Care System, Second Implementation (CHCS II) to provide more comprehensive, efficient electronic medical record support for all Department of Defense (DoD) beneficiaries.

2. Continue as planned to enhance, and ultimately absorb, the Composite Health Care System, First Implementation (CHCS I) into CHCS II through phased implementation of CHCS II.

3. Ensure that appropriate analytical and ad hoc reporting capabilities are available for CHCS II data to provide pertinent assessment information for management at all levels within and across the military Services and for all healthcare settings of the military.

4. Ensure that a longitudinal electronic health record exists for active duty military personnel, maintained through a global capability to link pertinent information data bases available for peacetime and deployed operations.

5. Participate actively in national and federal interagency policy and data standards development activities with organizations such as the National Committee on Vital and Health Statistics.

6. Plan, program, budget, and fully fund business process reengineering resource requirements to facilitate full implementation of the MHS Optimization Plan and Force Health Protection.

7. Strategic goals must be established to progressively enhance "connectivity" with Computerized Patient Records (CPRs) generated by managed care network providers and other providers not in the direct care system. When feasible, such integration must support common (uniform) data quality standards, data aggregation, audit, and robust analytical and report generation capabilities.

CHAPTER I
Upgrade Professional Education and Training Requirements for Military Physicians and Other Healthcare Providers

Panel Recommendations

1. Performance expectations for all healthcare providers, military or civilian, should be defined and assessed through an ongoing competency assessment program.

2. The plans of the Services covering compliance with Congress's mandate and Department of Defense (DoD) policy memoranda on General Medical Officers (GMOs) should proceed. The Services must ensure that providers assigned have the clinical skills necessary to care for the population served.

3. Physicians and other healthcare providers working in isolated situations should receive technological and resource support (e.g., decision support tools, manpower, and adequate financial allocation) in addition to consultation and oversight.

4. Appointment and retention criteria, performance expectations, and monitoring should be analogous and comparable for all healthcare providers, whether civilian providers in our purchased care networks or "direct care" providers.

5. Strategies should be developed to enhance the measurement of performance and the assurance of quality in the "purchased care" sector.

History and Overview of the Initiative to Transition from General Medical Officers to Residency-Trained Physicians

GMOs have provided primary care in both operational and clinical settings for decades. Much of their legacy dates to a period when most military forces, including physicians, were drafted and most members of the forces were male and unmarried. The training for medical practice and the practice of medicine were also considerably different. Following graduation from medical school, all physicians participated in a one-year rotating internship that provided broad-based clinical experience as a foundation for pursuing independent practice of medicine.

With the explosion in medical knowledge and technology that has taken place in the past three decades and the implementation of an all-volunteer military force, the landscape of medical practice has changed considerably. Medical school education still takes four years, but curricular changes have allowed for increasing elective time, especially during the final year. (Less common or core skills cannot always be assumed.) With an increased emphasis on specialization, categorical internships have all but replaced rotating internships in allopathic hospitals (osteopathic hospitals still require a rotating internship), followed by residency training in one's chosen specialty. This change alone has provided less cross-field exposure. Further, most Service members are now married and have families. Women now make up approximately 14 percent of the active military forces. And the numbers of elderly retirees and their family members have increased as well.

In the context of an aging population, a continuing, rapid increase of medical knowledge, and a concern about general (or perhaps basic) medical care skills, more states (currently 11) are requiring two or more years of training experience after graduation from medical school before a physician may be granted a full and unrestricted license to practice within their jurisdiction.

Concerns Regarding Utilization of General Medical Officers

While the Services still have a higher percentage of physicians successfully trained to a board-certified level than does the general civilian community, and while GMOs continue to do an exemplary job meeting the needs of the Services, the challenges have become more numerous. The skills learned in a hospital-based internship have typically become more narrowly focused, and in some cases they are harder to translate into ambulatory or operational environments, especially given the increased variety in the patient population being served. Provision of supplemental or "just-in-time" training became necessary to improve the capabilities of the individual physician to meet increasing expectations, which now included health promotion and disease prevention in addition to evaluation, diagnosis, and treatment of medical conditions. Increasingly, the question has been asked, "Is only one year of training after medical school sufficient to meet the increasing healthcare needs of our beneficiary population—especially in solo or isolated situations with limited opportunity for consultation with, or supervision by, physicians with more clinical experience or specialized expertise?"

DoD and Service Responses to Concerns

In January 1998, the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) responded to the Cox News Service articles by presenting to Congress 13 areas for improvement, one of which was to gradually decrease and ultimately eliminate GMO positions in favor of positions requiring fully (residency) trained physicians. On April 8, 1998, the acting Assistant Secretary of Defense for Health Affairs sent a memorandum to the Service Secretaries directing the Services "to neither recruit nor access physicians with less than a full residency"—the only exception being a physician brought directly into a residency program as a trainee. Thus the policy was established that only physicians with a minimum of three years of graduate medical education (GME) and/or board certification or board eligibility in primary care would be assigned to isolated situations. Under the policy, physicians who were already in practice but had less than three years of training could be granted a waiver to practice in isolated locations if they had demonstrated expertise acquired in operational and clinical settings, but waivers could be granted only for a finite period and only to physicians who entered the Service before 1999.

Services presented their proposed plans for phasing out GMOs to OASD(HA) by April 30, 1998. House Appropriations Committee Report No. 105-591 on H.R. 4103, the Department of Defense appropriations bill for fiscal year 1999, directed DoD to "phase out the use of General Medical Officers...and replace them with board-eligible primary care specialists within the next six years." In addition, the Committee directed the Assistant Secretary of Defense (Health Affairs), in coordination with the Surgeons General, to submit a report to the congressional defense committees by February 1, 1999, on the DoD's plan to phase out the use of GMOs. On February 24, 1999, OASD(HA) submitted the requested Report to Congress and restated the DoD's commitment to supporting the effort of each Service to make the conversion to fully trained specialists and to monitor plans to ensure full compliance.

Because of each Service's unique mission requirements and array of forces, no two plans were identical. Factors that affected the various plans included the cap on GME or residency training billets, the length of training required, the ability to attract qualified candidates to primary care specialties (family practice, internal medicine, pediatrics, emergency medicine, etc.), and retention rates of trained personnel. A consensus emerged that while the total number of GMOs could be minimized, it was not possible (nor was it desirable) to eliminate them completely. (For example, residents in training who choose to change specialties or drop out of training programs for a variety of justifiable reasons must finish their active duty service commitment in some defined GMO capacity.)

The Army devised a multipronged approach to achieve its goal in five years. All maneuver brigade surgeon positions will be replaced with residency trained officers over a three-year period. By matching as many training opportunities as possible to categorical residencies, the Army is trying to reduce the number of undesignated training billets. Medical students not selected for Post Graduate Year-1 (PGY-1) positions in military facilities will be granted full deferrals to complete their specialty training. Transitional positions will be matched to residency training positions at the end of the first year. Training billets in family practice, internal medicine, emergency medicine, and pediatrics will be increased. The Army is also trying to increase the number of residency opportunities available to current GMOs. GMOs assigned to remote areas will be reviewed for possible conversion to fully trained providers. The current applicant pool is not sufficient to increase the number of training positions in primary care specialties, because the number of scholarships available under the Health Professions Scholarship Program (HPSP) is now limited.

The Navy convened a GMO Task Force to resolve quality of care issues and determine which type of provider meets the needs of both beneficiaries and the organization. It found an equivalent level of satisfaction among service members for the care received from a GMO and the care received from a specialist. GMOs had the lowest percentages of both adverse privileging actions and legal investigations. Among primary provider specialties in the Defense Practitioner Data Bank, GMOs accounted for 4.7 percent of the malpractice cases. In reviewing more than 1,026 operational billets, the Task Force found that GMOs could appropriately fill 585 of them. Three factors determined the need for a higher level of expertise: the potential medical problems of the population served, the need to answer consults or accept referrals, and the need for expertise to supervise other healthcare practitioners.

The Navy, armed with this information from its Task Force, developed a plan to match the physician skill set with the patient and mission needs. Key components of the plan were to convert additional GMO billets to medical specialist billets in the year 2000; to restore the number of graduates from the HPSP, the primary source of candidates

for training in specialties, to previous levels by lifting the current lid on the number of scholarships available; to increase the number of Family Practice training opportunities; and to review military medical billets for their potential for conversion to other types of providers (military or contract).

In the Air Force, while GMOs are licensed independent providers, the department chief for whom they work monitors their delivery of healthcare. The Air Force plans to reduce authorizations for GMO positions by 20 percent per year. It has also decided not to retain a physician on active duty past his/her active duty service commitment unless he/she opts for specialty training. The Air Force, too, will seek to increase input into the HPSP.

Panel Deliberations

Copies of the DoD policy memorandum and the Report to Congress were provided to each member of the Healthcare Quality Initiatives Review Panel. The Panel established the working definition of a GMO as a physician who has completed one or more years of GME but has not successfully completed a residency training program. Panel discussions mostly involved clarifying points that had been made in the presentations by the individual Services. It was reemphasized that OASD(HA) has left it up to each Service to determine how to accomplish the transition. It was also emphasized that personnel making assignments need to conscientiously match the skill set of the provider to the requirements of the billet because all billets or positions available for GMO assignment are not equivalent.

It was clear that the Services have other efforts under way that will help to improve consultation and supervision of all providers, especially isolated ones. Key strategic examples include telemedicine, automated decision support tools, and manpower resourcing methodologies (primary care optimization or the enrollment-based reengineering model).

The Panel repeatedly heard concerns that contracted network or "purchased care" providers be held to the same standard of quality as "direct care" providers, especially because the Managed Care Support Contracts (MCSCs) do not require that providers in the network be board certified. Furthermore, non-network civilian providers have less stringent requirements under contracts.

Panelists thought that efforts to upgrade professional education and training requirements for the military should apply to all healthcare providers and not be limited to the transition from GMOs to residency-trained physicians. To help in this undertaking, quality management programs (including risk management experience) should be utilized to identify strengths and problems in performance and allow identification of trends to focus and improve available consultation, supervision, education, and training. Standards of preparation for quality management personnel and their continuing education requirements play an important role in assisting these improvement efforts.

Panel Conclusions

1. A dynamic competency assessment program is essential to coordinate the information needed to align providers with operational needs and to develop training requirements for all military healthcare providers.

2. The Panel recognizes that DoD and the Military Health System (MHS) have initiated rational approaches to minimize the number of GMOs assigned and to optimize the oversight and performance of GMOs that are required.

3. Assignment criteria, performance expectations, and monitoring of contract physicians working within military treatment facilities have been

enhanced and are equivalent to those affecting their military counterparts.

4. Performance expectations have been appropriately enhanced to guide retention of physicians.

Panel Recommendations

1. Performance expectations for all healthcare providers, military or civilian, should be defined and assessed through an ongoing competency assessment program.

2. The plans of the Services covering compliance with Congress's mandate and Department of Defense (DoD) policy memoranda on General Medical Officers (GMOs) should proceed. The Services must ensure that providers assigned have the clinical skills necessary to care for the population served.

3. Physicians and other healthcare providers working in isolated situations should receive technological and resource support (e.g., decision support tools, manpower, and adequate financial allocation) in addition to consultation and oversight.

4. Appointment and retention criteria, performance expectations, and monitoring should be analogous and comparable for all healthcare providers, whether civilian providers in our purchased care networks or "direct care" providers.

5. Strategies should be developed to enhance the measurement of performance and the assurance of quality in the "purchased care" (contracted managed care network) sector.

CHAPTER II
Establish Centers of Excellence for Complicated Surgical Procedures

Panel Recommendations

1. The current effort to develop a program to designate Centers of Excellence (COEs) within and for the Department of Defense (DoD)/Military Health System (MHS) should be aggressively pursued. This program will be based on the criteria created by the Center of Excellence Project.

2. Pilot testing of the COE designation process, criteria, metrics, and organizational evaluation process should be completed for selected sets of Diagnosis Related Groups (DRGs) on an aggressive timetable.

3. A representative forum of significant federal and nonfederal constituencies should evaluate early pilot experience and use the information to facilitate refinement and broader implementation.

4. Essential metrics for clinical and administrative COE program elements should be incorporated into DoD/MHS automation initiatives as experience indicates.

History and Overview

The Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) established policies for the creation of Specialized Treatment Services (STS) facilities that would recognize and focus clinical resources to create operational efficiencies and foster excellence of services throughout the MHS.

A number of clinical areas represent complex, high-cost, high-risk procedures (Appendix II.1 at the end of this chapter). Facilities that want to offer one or more of these specific services must apply to the TRICARE Management Activity (TMA) to become designated STS facilities. Information required to justify such designation includes description of physical plant, qualifications of personnel, and various process factors that could address stability of resources and volume of experience.

Because cost was a major concern of the STS effort, applicant facilities must show that their proposed plan will cost the government less than if the same procedures were performed in the local civilian sector.

During the 22 months that the program has been under review, a number of issues have been raised. Recommendations from the review address these issues and will be more fully discussed below. For purposes of clarity in this overview, it is necessary to note that one of these issues is the increase in "catchment area" granted by designation as an STS. An implication of this extension is that the facility has the authority to disapprove a request for a Non-Availability Statement (NAS) for designated procedures throughout the catchment area. Thus patients who need treatment under a designated DRG would be obligated to pay out-of-pocket (potentially the entire cost) if they chose not to have care in the applicable STS facility and an NAS is not granted.

The COE designation was added to existing policy after the STS program had been developed. Several military treatment facilities (MTFs) conveyed a desire to provide care and treatment for DRGs that policy had restricted to STS facilities. These facilities, however, did not want to exercise extended NAS disapproval authority or incur additional expenses for travel and per diem obligated by designation as an STS. The requirement to demonstrate fiscal benefit to the government in providing the designated medical service/treatment within the MTF was regarded as onerous and not credible because there was (and is) no system of approved metrics to assess and compare resource costs among the military medical services and between the military and civilian sectors (e.g., the military system has never been managed with a billing system).

Applications for STS or COE status were reviewed by TMA in a process that included representatives of Clinical Operations, the Office of the General Counsel, and Resource Management Directorates. At the recommendations of the reviewers, the Executive Director of TMA granted or denied STS or COE status depending on the strength of the application.

A list of MTFs that have been granted STS or COE status is attached as Appendix II.2 at the end of this chapter.

Concerns Regarding STS/COE Policies

TMA had been reviewing the policies establishing and guiding STS/COEs for more than a year and a half at the time of the development of this report. This review has noted several concerns with the design and implementation of the programs, including the following:

1. Despite a good-faith effort to fairly assess the qualifications and justifications provided by MTFs, there are no pertinent, comprehensive, widely recognized national criteria for the spectrum of DRGs covered under the STS/COE policies. (This is also a concern of the health insurance industry and the Health Care Financing Administration [HCFA].)

2. Concerns have been expressed about the burden placed on patients and their families when patients must travel considerable distances and reside away from home for an extended time to obtain treatment at a designated facility.

3. STS/COE policies do not prevent discontinuities in care. In many cases, patients undergo initial diagnosis and treatment "outside" of the STS/COE and then are required to "come in," which often causes significant challenges in communication and relationship building.

4. There has been a perception that the real drivers of the STS/COE programs have been fiscal savings (not coupled with high-quality outcomes) and enhancement of experience for specific Graduate Medical Education (GME) programs (again, not necessarily coupled with high-quality clinical outcomes).

5. No data have been produced that establish or relate fiscal experience to clinical outcomes or establish that efficiencies have been achieved in the context of proven clinical excellence.

Some recommendations considered in past reviews include:

1. Eliminate the NAS disapproval authority currently associated with STS designation. (This would allow patients to choose to have treatment at an MTF if they wished. It would force MTFs to attract patients rather than be perceived as coercing patients into receiving care in the direct care system.)

2. Develop criteria based on evidence and expert "best wisdom" to define COE designations across the spectrum of DRGs identified for the program.

3. Pursue the development of criteria (as above) under contract support to ensure credibility by involving a broad cross-section of clinical experts and other constituencies. (Such development would also involve comprehensive literature review and meta-analysis modified and validated by panels with expertise in the area or issue.)

4. In the criteria development effort, plan for ongoing monitoring, oversight, and "rectification" of facilities after they are designated.

These four recommendations are under further evaluation, facilitated by the Panel's designation of funds (apportionment of $600,000) to enhance DoD healthcare quality initiatives.

The Panel was briefed on the progress of the Center of Excellence Project. Significant accomplishments included a set of COE designation criteria covering nine clinical areas and 30 DRGs. These criteria sets are a seminal achievement that undoubtedly will evolve. There are very few consensus or evidence-based criteria sets in either the private or the public sector that establish clinically and scientifically justifiable criteria for the assessment, designation, and monitoring of a medical facility aspiring to clinical excellence. The credibility of this effort is further enhanced by the participation of military and civilian experts and representatives from the Department of Veterans Affairs and the Department of Health and Human Services (through HCFA) in the development of the criteria. With the authorization of TMA, HCFA is initiating the use of two of the criteria sets (Cardiac Surgery and Orthopaedic Surgery) in a pilot project for Center of Excellence Designation in the Medicare system.

Panel Deliberations

The Panel was briefed on the history and concerns summarized above. It reviewed in detail pertinent available studies and considered some earlier similar efforts to address analogous issues, such as the efforts by HCFA. (Although these were pioneering efforts and offered some useful experience, they did not offer a resolution to the current problem.) Further, the Panel came to understand that the civilian sector often uses the term "Center of Excellence"as a self-designation—apparently for marketing purposes—that is rarely, if ever, validated independently through a process using evidence and consensus-based criteria and metrics.

The Panel is very impressed with the results of this project and hopes that it is carried forward and further developed. Even now, its dissemination and implementation have the potential to have a profound impact on the face of healthcare in America.

Panel Conclusions

1. The concept of designating facilities, military or civilian, as COEs to provide selected specialized, complex treatments to DoD/MHS

beneficiaries is appealing and offers great potential benefit.

2. To date, the DoD/MHS (and the nation) have lacked an accepted process to designate such facilities through evidence-based criteria, consensus-based criteria, utilization evidence, and supportive metrics; a periodic mechanism for evaluation has also been lacking.

3. Further development and testing of this COE approach offers the potential for establishment of a defensible standard and will enhance clinical quality and accountability.

4. Additional benefits that may also be derived and related to this development include:

    a. Options for "tri-Service" assignments of active duty military specialist personnel;

    b. Rational, experience-based treatment counseling and education for patients, staff, and decisionmakers;

    c. Use of interagency sharing capabilities and of civilian academic medical centers; and

    d. Sizing and maintenance of appropriate specialty resources, including personnel, within active duty and reserve military medical components.

Panel Recommendations

1. The current effort to develop a program to designate Centers of Excellence (COEs) within and for the Department of Defense (DoD)/ Military Health System (MHS) should be aggressively pursued. This program will be based on the criteria created by the Center of Excellence Project.

2. Pilot testing of the COE designation process, criteria, metrics, and organizational evaluation process should be completed for selected sets of Diagnosis Related Groups (DRGs) on an aggressive timetable.

3. A representative forum of significant federal and nonfederal constituencies should evaluate early pilot experience and use the information to facilitate refinement and broader implementation.

4. Essential metrics for clinical and administrative COE program elements should be incorporated into DoD/MHS automation initiatives as experience indicates.

APPENDIX II.1

High-Cost, High-Risk Procedures

MD Specialty	Procedures	DRGs
Neurosurgery and Orthopedics	Craniotomy, Spinal Procedures	1, 3, 4
ENT, Oral Surgery, or Plastic Surgery	Major Head and Neck Procedures	49
CV Surgery and Interventional Cardiology	Major Cardiac Procedures, e.g., Valve and CABG with and without Invasive Cardiology Procedures	104, 105, 106, 107, 110, 111
General Surgery	Pancreas, Liver and Shunt Procedures, Adrenal and Pituitary Procedures	191, 286
Orthopedics	Major Joint and Limb Reattachment Procedures (i.e., total joint replacement in the Upper and Lower Extremities)	209, 491
Transplant, General Surgery, and Oncology	Kidney, Liver, and Bone Marrow Transplants	302, 480 ,481
Neonatal	Prematurity and Other Significant Neonatal Problems	386, 387, 389, 390
GYN Oncology	Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy	357
Burns (General and Plastic Surgery)	Extensive Burns with and without Surgery or Other Trauma	504, 505, 506, 507, 508, 509, 510, 511

APPENDIX II.2

Specialized Treatment Service (STS) Facility List

Regional STS Facilities

Facility	STSs	Effective Date	Lead Agency Contact
Region 1			
National Naval Medical Center (NNMC), Walter Reed Army Medical Center (WRAMC), and Malcolm Grow Medical Center (MGMC)	General Surgery and Orthopedic Surgery. DRGs 191, 209, 286 (Adrenal), and 491	Sept. 1, 1999	CAPT Michael Jones (202) 782-1483 DSN: 662-1483 NNMC POC: CDR Winette Isley (301) 295-6195 WRAMC POC: (202) 782-4302 MGMC POC: Capt Warwar (301) 981-2475
National Naval Medical Center and Walter Reed Army Medical Center	Neurosurgery, Otorhinolaryngology Surgery, and Gynecologic Oncology Surgery. DRGs 001, 003, 004, 049, 286 (Pituitary), and 357	Sept. 1, 1999	CAPT Michael Jones (202) 782-1483 DSN: 662-1483 NNMC POC: CDR Winette Isley (301) 295-6195 WRAMC POC: (202) 782-4302
Region 3			
Eisenhower Army Medical Center (EAMC)	Cardiac Surgery and Interventional Cardiology. DRGs 104, 105, 106, 107, 108, and 112	March 1, 1997	LCDR Leesa Kent (706) 787-3016 DSN: 773-3016 EAMC STS Project Officer: COL Richard Traugott (706) 787-8288 DSN: 773-8288
Eisenhower Army Medical Center (EAMC)	Neurosurgery, Orthopedic Surgery, General Surgery, Peripheral Vascular Surgery, and Head and Neck Surgery. DRGs 001, 004, 049, 109, 110, 111, 191, 209, 286, and 491	Sept. 1, 1999	LCDR Leesa Kent (706) 787-3016 DSN: 773-3016 EAMC STS Project Officer: COL Richard Traugott (706) 787-8288 DSN: 773-8288

Facility	STSs	Effective Date	Lead Agency Contact
Region 4			
Keesler Medical Center (KMC)	Neonatal Intensive Care. DRGs 370, 372, 383, 604, 607, 611, 612, 613, 617, 618, 622, 626, and 636 Cardiac Surgery. DRGs 104, 105, 106, 107, 108, 110, 111, 112, 124, and 125	May 1, 1998	Col Joe Taylor (228) 377-9643 DSN: 597-9643 KMC POC: MSgt. Belinda Skelton (228) 377-3103 DSN: 597-3103
Keesler Medical Center (KMC)	General Surgery, Orthopedic Surgery, Neurosurgery, Otorhinolaryngology Surgery, and Gynecologic Oncology Surgery. DRGs 001, 003, 004, 049, 191, 209, 286, 357, and 491	May 1, 2000	Col Joe Taylor (228) 377-9643 DSN: 597-9643 KMC POC: MSgt. Belinda Skelton (228) 377-3103 DSN: 597-3103
Region 6			
Brooke Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC) (Destination San Antonio Facilities)	General Surgery, Orthopedic Surgery, Neurosurgery, Otorhinolaryngology Surgery, Gynecologic Oncology Surgery, and Cardiothoracic Surgery. DRGs 001, 003, 004, 049, 104, 105, 106, 107, 110, 111, 191, 209, 286, 357, and 491	Sept. 1, 1999	Maj Brandsma (210) 292-3256 DSN: 554-3256
Region 9			
Naval Medical Center San Diego (NMCSD)	General Surgery, Orthopedic Surgery, Neurosurgery, Otorhinolaryngology Surgery, Gynecologic Oncology Surgery, and Cardiothoracic Surgery. DRGs 001, 003, 004, 049, 104, 105, 106, 107, 110, 111, 191, 209, 286, 357, and 491	Sept. 1, 1999	MAJ Kelly Wolgast (619) 532-6169 DSN: 522-6169 NMCSD POC: LT Karen Leahy (619) 532-5573 DSN: 522-557
Region 10			
David Grant Medical Center (DGMC)	General Surgery, Orthopedic Surgery, Neurosurgery, Otorhinolaryngology Surgery, Gynecologic Oncology Surgery, and Cardiovascular Surgery. DRGs 001, 003, 004, 049, 110, 111, 191, 209, 286, 357, and 491	Sept. 1, 1999	Lt Col Pamela Cygan (707) 424-6533 DSN: 350-6533 DGMC POC: Maj Robert Jordan (707) 423-7545 DSN: 799-7545
VA Palo Alto Health Care System and San Francisco VA Medical Center	Cardiothoracic surgery. DRGs 104, 105, 106, 107, 108, and 109	Nov. 1, 1999	Lt Col Pamela Cygan (707) 424-6533 DSN: 350-6533 VA STSFs POC: Mr. Eric Raffin (650) 849-0113

Multiregional STS Facilities

Facility	STSs	Effective Date	Lead Agency Contact
Regions 1 and 2			
Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC)	Cardiothoracic and Peripheral Vascular Surgery. DRGs 104,105, 106,107, 108, 110, and 111	October 1, 1997	CAPT Michael Jones (202) 782-1483 DSN: 662-1483 Ms. Kendra Drew (202) 782-4302 NNMC POC: CDR Winette Isley (301) 295-6195 Region 2 STS POC: Maj David Petray (757) 314-6455
Regions 1, 2, and 5			
Walter Reed Army Medical Center (WRAMC)	Liver Transplant. DRG 480	Sept. 1, 1999	CAPT Michael Jones (202) 782-1483 DSN: 662-1483 WRAMC POC: Ms. Kendra Drew (202) 782-4302 Region 2 STS POC: Maj David Petray (757) 314-6455

National STS Facilities

Facility	STSs	Effective Date	Lead Agency Contact
Wilford Hall Medical Center (WHMC)	Allogeneic Bone Marrow Transplantation. DRG 481	October 1, 1997	Maj Brandsma (210) 292-3256 DSN: 554-3256 WHMC POC: Maj David Ririe (210) 292-7391 DSN: 554-7391
Walter Reed Army Medical Center (WRAMC)	Kidney Transplant. DRG 302	Sept. 1, 1999	CAPT Michael Jones (202) 782-1483 DSN: 662-1483 WRAMC POC: Ms. Kendra Drew (202) 782-4302

STS Facility Catchment Area Directory POC:
Mr. Jim Johnston, TRICARE Management Activity, (703) 681-6124

TRICARE Management Activity (TMA) Points of Contact:
Daniel Cohen, Col, USAF, MC, FS, TMA Chief Medical Officer
(703) 681-0064
Mr. Tariq Shahid, TMA-Aurora STS Project Officer
(303) 676-3801, DSN: 926-3801

CHAPTER III
Make Timely and Complete Reports to the National Practitioner Data Bank (NPDB) and Eliminate Associated Reporting Backlogs

Panel Recommendations

1. Improve the Department of Defense (DoD) Risk Management Program by using an integrated tri-Service process to address cases, perform analysis, and provide coordination with external agency peer review and the Department of Legal Medicine (DLM)/Armed Forces Institute of Pathology (AFIP). (See Chapter V.)

2. Include Risk Management Program information about actions of significance in the DoD Quality Management Report (QMR). (See Chapter V.)

3. Use risk management experience to develop educational products that healthcare professionals and other participants in healthcare services can use to improve safety and reduce risk.

4. Use common metrics in reporting aggregated and stratified risk management experience to facilitate comparisons and analyses of trends.

5. Modify the DoD Risk Management Program to require a uniform comprehensive process for identification and reporting of practitioners not meeting the standard of care in claims by active duty Service members (Feres-barred cases).

6. Require Managed Care Support Contractors (MCSCs) to develop processes for risk management and error reduction that are analogous to those used in the direct care system.

History and Overview of the NPDB and DoD Policy/Participation

The NPDB was established to implement the Healthcare Quality Improvement Act of 1986, Title IV of Public Law 99-660, enacted on November 14, 1986. The Act authorized the Secretary of Health and Human Services to establish a national data bank as a key strategy to prevent unethical or incompetent healthcare practitioners from compromising the quality of the public's care. The data bank acts as a central

repository of information on healthcare practitioners for malpractice payments, adverse actions (licensure, privileges, professional review, Drug Enforcement Administration actions), and, since 1997, Medicare/Medicaid exclusions. The NPDB opened on September 1, 1990, with the goal of restricting the ability of unethical or incompetent healthcare practitioners to move from state to state without disclosure or discovery of information relating to potentially damaging or incompetent performance.

The NPDB is used by authorized and registered healthcare entities (hospitals, health maintenance organizations, licensure boards, professional societies, peer review bodies) to query for and report specific information (malpractice payments, adverse actions, etc.) on healthcare providers. To date, about one in six physicians and one in eight dentists in active practice have one report in the data bank.

The DoD policy for querying and reporting to the NPDB was established on November 1, 1990, through DoD Directive 6025.14, "DoD Participation in the NPDB." Implementation was structured through a memorandum of understanding with the Department of Health and Human Services in September 1987. Formal implementation of the policy was directed on November 9, 1992, through DoD Instruction 6025.15, "Implementation of DoD Participation in the NPDB." The DoD Instruction describes under what circumstances a healthcare provider (a physician or dentist) working for the direct care system should be reported to the NPDB and the process for determining if a report should be made. For malpractice claims, the evaluation process initially involves an investigative fact-finding process for each instance of alleged malpractice at a military treatment facility (MTF) or dental treatment facility. Involved practitioners provide input. The appropriate Surgeon General conducts a review of care to determine whether the standard of care was met and to review the processes and factors leading to the claim.

For claims that result in a malpractice payment, whether the standard of care was met or not met, all providers that the investigative fact-finding process determines were involved with the case are allowed to submit written comments about their involvement to the Surgeon General's Office (SGO). The Surgeon General reviews the investigative fact-finding process, professional (and peer) reviews including a recommendation from the local entity's credentials committee, a summary of the administrative claim adjudication and/or litigation disposition, and comments by the involved providers. If the Surgeon General determines that a malpractice payment was made for the benefit of a healthcare practitioner, a report is made to the NPDB in the name of the practitioner. (A practitioner is reported to the NPDB for malpractice if he or she is responsible for an act or omission of an act that was the cause of the harm that gave rise to the payment and if the standard of care was not met. Practitioners are also reported if payment was the result of a judicial determination of negligence and was based on the act/omission, or if the payment was the result of an administrative or litigation settlement that, based on the record as a whole, required a report to be made.)

For adverse actions, reports are made to the NPDB and appropriate state licensing boards when privileges are denied, limited (restricted), or revoked for incompetence or improper professional conduct. Such actions, although reviewed and reported by the appropriate Surgeon General, are usually initiated by the credentials committee and the commander of the facility to which the practitioner is assigned and in which he or she is privileged.

The Services' processes for reporting to the NPDB are based on the DoD Instruction. Each Service has its own process, but all are generally similar in nature and follow the DoD Instruction.

Concerns Regarding Reporting to the NPDB

Concerns about reporting to the NPDB are related to backlogs of paid malpractice cases not brought to conclusion by the SGOs, lack of reporting of healthcare providers to the NPDB, and active duty claims (Feres-barred cases) not reportable to the NPDB because no malpractice payment is involved.

Service Reporting Backlogs and Lack of Reporting to the NPDB

Although most of the Services started reporting to the data bank in 1991, over the years none had maintained their requirement to report healthcare providers for malpractice and had developed backlogs of malpractice cases, primarily because lack of personnel resources made it difficult to keep up with the workload. Statistics from the NPDB and an audit by the DoD Inspector General (IG), concluded in June 1998, confirmed that a significant lack of reporting and backlog existed. Table One displays statistics from 1991 to 1999 for reporting healthcare providers for malpractice to the NPDB by each of the Services.

Table Two displays physician malpractice reporting rates to the NPDB for DoD and the United States. The rate of DoD physician malpractice reports per 1,000 physicians is well below the mean rate for the United States as a whole and is on the low end of the range of all states reporting to the NPDB.

One reason DoD reporting is low may be that the data portrayed do not include Feres-barred cases. Feres-barred cases involve active duty Service

TABLE ONE

Healthcare Provider Reports Made to the National Practitioner Data Bank (NPDB) for Malpractice Payments (by Service and Calendar Year)

Totals	1991	1992	1993	1994	1995	1996	1997	1998	1999
Army*									
Annual	3	11	14	0	0	5	2	80	66
Cumulative	3	14	28	28	28	33	35	115	181
Navy*									
Annual	0	0	11	16	4	7	9	49	30
Cumulative	0	0	11	7	31	38	47	96	126
Air Force*									
Annual	12	17	55	21	42	50	35	20**	10**
Cumulative	12	29	84	105	147	197	232	252	262
Service Totals									
Annual	15	28	80	37	46	62	46	149	106
Cumulative	15	43	123	160	206	268	314	463	569

Note: NPDB numbers include physicians, dentists, and certain other nonphysician healthcare providers. The majority (82%) are physicians.

* Data Source: Division of Quality Assurance/Health Resources and Services Administration, February 10, 2000.

** Data are incomplete for these years because of unresolved backlog.

members, and by statute they cannot be reported to the NPDB because no malpractice payment was made. Active duty Service members account for approximately 20 percent of the beneficiary population.

Another reason DoD reporting is low may be that DoD does not report healthcare providers for whom a malpractice payment has been made unless the standard of care was not met. If the standard of care was met, the healthcare provider is not reported. Approximately 50 percent of military cases with claims paid meet the standard of care. This policy was intended to balance the civilian sector's use of "corporate shield" to limit reporting of healthcare providers in certain circumstances. Corporate shield is a settlement in which a codefendant healthcare organization is named instead of the practitioners, who would otherwise be reported. This is common procedure when the defendant organization is responsible for the malpractice coverage of the codefendant employee practitioner. If a practitioner is named in the claim but not in the settlement, no report is required to be filed with the NPDB. Finally, care in the "direct care" system may actually be associated with a lower incidence of malpractice.

Table Two was developed as an ad hoc report specifically for the Panel. The Panel believes that such review and trend analysis is of substantial value and should be built from standardized data

TABLE TWO

Physician Malpractice Reporting Rates to the National Practitioner Data Bank (NPDB) for the Department of Defense (DoD) and United States

	DoD			United States	
Year	* Physician Malpractice Reports to NPDB	** Number of Physicians	Rate: Physician Malpractice Reports Per 1,000 Physicians	*** Mean Rate: Physician Malpractice Reports Per 1,000 Physicians	**** Rate Range: Physician Malpractice Reports Per 1,000 Physicians
1994	31	14,625	2.1	23.9	5.5 to 66.8
1995	38	13,383	2.8	21.1	7.2 to 50.8
1996	50	12,744	3.9	22.3	8.0 to 58.4
1997	32	13,347	2.4	20.1	6.0 to 38.45
1998	130	13,756	9.5	21.2	5.7 to 37.2
1999	88	12,194	7.2	N/A	N/A

* Data Source: National Practitioner Data Bank

** Data Source: *US Medicine: Federal Market Facts*—includes MDs, DOs, and residents.

*** Data Source: National Practitioner Data Bank 1998 Report, Table 9. Rate depicted is the mean of the rates of all of the states.

**** Data Source: National Practitioner Data Bank 1998 Report, Table 9. Rate depicted is the range of the states' reporting rates. Rates rounded to nearest tenth of a percent.

N/A: Data are not available in the National Practitioner Data Bank 1999 Report.

collection within the Services for aggregate evaluation at the levels of the SGO and Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA])/TRICARE Management Activity (TMA). Types of standardized data for collection are suggested below.

- Denominators consisting of the number of healthcare providers for each Service in the direct care system, which can be divided into specific healthcare provider categories such as physicians, dentists, and nonphysicians
- Number of malpractice payments and adverse actions per calendar year within each Service
- Number of malpractice and adverse action reports made by each Service to the NPDB per calendar year
- Turnaround time to submit malpractice and adverse action reports to the NPDB
- Backlogs of malpractice cases or adverse actions
- Total number of cases and healthcare providers sent by the SGO for external peer review per calendar year, with preliminary determinations of standard of care met or a system problem
- Total number of cases and healthcare providers for which the external peer review agency agreed or disagreed with the SGO's determination of meeting the standard of care or having a system problem
- Total number of cases and healthcare providers for which the SGO agreed or disagreed with the external peer review agency's determination of standard of care or system problem, along with reasons for disagreement. (The process of external peer review for standard-of-care corroboration is discussed later in this chapter.)
- Total number of cases and healthcare providers regarding which the SGO changed its determination to one that agreed with the external peer review agency's determination

Feres Doctrine Barred Cases

Another concern involved Feres-barred cases. Active duty personnel are barred from suing the federal government because of the Feres Doctrine, which is based on the 1950 Supreme Court decision in Feres v. United States. The key issue here and under subsequent reviews has been protection of command discipline. In the medical area, the Military Health System (MHS) provides medical care to service members for any injuries that may occur from any cause. As a result, when an active duty Service member files a malpractice claim for medical malpractice, the claim is denied based on the Feres Doctrine and no payment is made. For such Feres-barred cases, any disability resulting from medical care is managed and compensated for under the disability system, supported by a thorough arbitration review mechanism. Approximately 20 percent of the DoD beneficiary population are active duty personnel. By statute, Feres-barred cases involving active duty service members cannot be reported to the NPDB because no malpractice payment is made.

Efforts to Address Reporting Backlog, Lack of Reporting, and Feres-Barred Cases

The Services and the MHS responded to these deficiencies with the following four initiatives:

- **Some of the Services hired contractors to reduce backlogs and increase reporting to the NPDB.**

  Some of the Services hired contractors to eliminate backlogs that had built up over the years due to a lack of personnel resources. Within one year, the Services with backlogs

were able to manage their caseloads and increase reporting to the NPDB substantially, as indicated in Table One for the years 1998 and 1999. Despite these efforts, the Services have not consistently been able to prevent backlogs from developing.

As of November 2000, the Navy has no backlog of paid malpractice cases, and the Army has a backlog of 80 cases. The Air Force hired three contractors in July 2000 to inventory its malpractice cases. The contractors found 625 open malpractice cases, of which about half are paid malpractice cases in backlog. To eliminate the backlog, the Air Force Surgeon General is applying fiscal year 2001 funding to hire three additional contractors, streamline the medical malpractice evaluation process, and increase the number of SGO medical practice review boards.

- **OASD(HA)/TMA implemented the DoD Risk Management Committee in February 1998 to monitor malpractice reporting.**

  The DoD Risk Management Committee was established to monitor Service reporting to the NPDB and external peer review agency results, and to provide a forum to discuss related risk management issues. Each quarterly meeting has standard agenda items based on recommendations from the DoD IG Evaluation Report 98-168, which reviewed DoD implementation of NPDB guidelines. Major items reported at the meeting include Service metrics on malpractice and adverse actions, external peer review results for malpractice cases, and sentinel events. Other items discussed include metrics on Department of the Treasury reports on malpractice payments in DoD, closed medical malpractice cases from the Department of Justice, implementation of DoD IG recommendations, and any other issues that attendees need to raise about risk management. Issues that cannot be solved at the committee level are elevated to TMA and OASD(HA) for action. The committee's membership comprises risk management representatives from each of the Surgeons General Offices and their general counsel, representatives of OASD(HA) and TMA and their general counsel, and representatives from DLM/AFIP and the Department of Justice. The committee held its organizational meeting in February 1998 and now meets quarterly.

- **The Services added external peer review to the malpractice case review process at the Surgeons General level to provide an external opinion.**

  External agency peer review of malpractice cases was established to augment the review of the SGO by providing the Surgeon General with an additional opinion, one that is representative of the civilian community outside the military system, as to whether standard of care had been met. The review is specifically for cases with a preliminary determination from the SGO of standard of care met or a system problem. This determination is used, in addition to other professional reviews (from within the Service), by the Surgeon General to make the final standard of care determination, which is critical in deciding whether to report the healthcare provider to the NPDB.

- **OASD(HA)/TMA and the Services updated DoD Instruction 6025.15 to address Feres-barred cases and reporting timelines, requiring that they be subject to the same investigation, analysis, and reporting as any malpractice claim.**

  Table Three summarizes data compiled in March 2000 from a review of 250 providers evaluated by the external agency peer review process after the Services determined whether provider standard of care was met or whether a system problem resulted in the paid claim (data were from January 1998 through October 1999).

A total of 57 (23%) providers were determined to not meet the standard of care. The Surgeons General agreed with 32 of those determinations and disagreed with 8 (3%); 17 (7%) were still pending. As of November 2000, 10 of the 17 pending determinations had been resolved. The Surgeons General did not reverse the opinion of the external agency in any of these 10 determinations. The reason for any differences of opinion between the SGOs and the external peer review agency on standard of care determinations is that reasonable experts may, and sometimes do, have different opinions about the standard of care in medicine. This early experience of assessing agreement between differing peer review processes is a national pioneering effort that may prove useful in establishing benchmarks for monitoring such review processes.

To address Feres-barred cases, DoD Instruction 6025.15 has been updated to include such cases and is currently being staffed through TMA, OASD(HA), and the Directives and Records Department at the Pentagon. When it is determined that disability system or other payments will be made because of personal injury or death of a member of the uniformed Services caused by the failure of a practitioner to meet the professional standard of care, the Surgeon General must make a report to the Defense Practitioner Data Bank (DPDB), maintained by the DLM/AFIP in the name of the practitioner. (The DPDB consists of two DoD risk management databases that were created in 1988. They are the DoD Closed Medical Malpractice Case database called Tort 2 and the DoD Adverse Privilege Actions database called Clin 2. These two databases have been used for tracking medical malpractice cases and adverse privilege actions for the purposes of quality improvement in DoD.) Identifying these cases will require coordination of the disability system with the risk management system in each of the Surgeons General Offices. A work group is being formed to develop a process to accomplish this task.

TABLE THREE

Results of External Agency Peer Review: January 1998 through October 1999

Number of providers evaluated by external agency peer review with preliminary Service determinations of standard of care met by the provider or paid claim due to system problem	250	
External agency peer review agreed with Service determination	193	(77%)
External agency peer review disagreed with Service determination	57	(23%)
Services changed to external agency peer review's determination of standard of care not met by the provider	32/57	(56%)
Services did not change to external agency peer review's determination	18/57	(32%)
Services' final determination pending	7/57	(12%)

Data Source: Armed Forces Institute of Pathology/Department of Legal Medicine

Panel Deliberations

As summarized above, the Panel was briefed extensively by representatives from TMA, each of the Services, and DLM/AFIP on the malpractice reporting process in each of the Services, Service reporting to the NPDB, Service malpractice case backlogs, and external agency peer review of malpractice cases. DLM/AFIP also briefed the Panel on the DPDB, the meaning of standard of care, rules of negligence, DoD medical malpractice data, limitations and usefulness of malpractice data, and studies, articles, and publications (such as Legal Medicine Open File) developed using the DPDB data.

Panel deliberations encompassed the issues of reporting healthcare providers to the NPDB, eliminating malpractice case backlogs, results of external agency peer review of malpractice cases, updating DoD Instruction 6025.15, unavailability of MCSC risk management data, and establishing the DoD Risk Management Committee. The Panel discussed and confirmed that the initiatives taken by OASD(HA)/TMA and the Services to put NPDB reporting back on track are well focused and have shown early promise.

The addition of the external peer review agency has benefited the risk management process by providing the Surgeons General with an external opinion to consider when performing malpractice case deliberations, and it has had a positive effect on the process. Most important, it augments data and provides information for monitoring and assessing very important quality assurance processes from the level of the MTF to that of the SGO. It has also validated the Services' overall review process.

Improved management of backlogs through the use of contractor support is critical to reestablishing timely Service reporting to the NPDB. All efforts should be made to eliminate any present backlogs and, once they are eliminated, to prevent any future backlogs. The DoD Risk Management Committee will serve well for monitoring the risk management process and assessing the resources assigned to it.

The Panel understands that there is no uniform process for determining the standard of care related to Feres-barred cases, nor is there a satisfactory repository of data on such cases in the DLM/AFIP. Updating DoD Instruction 6025.15 to address Feres-barred cases is a positive step toward comprehensive risk assessment, reduction, and prevention.

The Panel noted the lack of risk management data available from the MCSCs relating to healthcare provided in the purchased care sector.

Panel Conclusions

1. The initiatives taken by OASD(HA)/TMA and the Services are well considered and show promise for the following:

    - Enhancing the accuracy and timeliness of reporting to the NPDB
    - Reducing malpractice case backlogs
    - Creating a forum for monitoring the risk management process
    - Enhancing risk reduction and prevention strategies in the direct care system

2. A lack of ability and data to make basic, ongoing comparisons persists among the Services; among the DoD, Department of Veterans Affairs, and other federal agencies; and between the military and civilian sectors using risk management data.

3. The MTFs, the Services, and OASD(HA)/TMA have failed to make uniform and sustained efforts to use the results of the risk management

process for system improvement across Services at all appropriate levels.

4. Alignment of personnel and other resources to improve safety (risk reduction and prevention) should be periodically examined and apportioned to enhance efficiencies, data generation, and analyses (especially comparative experience among the Services, other agencies, and the civilian sector).

5. Risk management educational initiatives should be performance-based; they should include patients, providers, and contractors; and they should anticipate needs for redesign and timely implementation of process. Such initiatives should be evaluated to assess their impact.

6. The absence of a uniform, mandated evaluation and reporting process for practitioners identified as not meeting the standard of care in Feres-barred cases is a serious deficiency of the risk management program.

7. The lack of data about MCSC risk management experience is a serious flaw that can defeat comprehensive system analysis, improvement, and resource alignment.

Panel Recommendations

1. Improve the DoD Risk Management Program by using an integrated tri-Service process to address cases, perform analysis, and provide coordination with external agency peer review and the Department of Legal Medicine (DLM)/ Armed Forces Institute of Pathology (AFIP). (See Chapter V.)

2. Include Risk Management Program information about actions of significance in the DoD Quality Management Report (QMR). (See Chapter V.)

3. Use risk management experience to develop educational products that healthcare professionals and other participants in healthcare services can use to improve safety and reduce risk.

4. Use common metrics in reporting aggregated and stratified risk management experience to facilitate comparisons and analyses of trends.

5. Modify the DoD Risk Management Program to require a uniform comprehensive process for identification and reporting of practitioners not meeting the standard of care in claims by active duty Service members (Feres-barred cases).

6. Require Managed Care Support Contractors (MCSCs) to develop processes for risk management and error reduction that are analogous to those used in the direct care system.

CHAPTER IV
Ensure That the Military Health System (MHS) Providers Are Properly Licensed and Have Appropriate Credentials

Panel Recommendations

1. The current direct care system licensure policy promulgated by Department of Defense (DoD) Directive should be continued within the context of a dynamic, quality management program that is increasingly based on performance data.

2. The Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) must continue to monitor state legislative initiatives on licensure of healthcare professionals and work with national entities to achieve uniformity of requirements, processes, assessment methodologies, and results.

3. The Centralized Credentials Quality Assurance System (CCQAS), the automation platform for credentials management in the direct care system, should be aggressively refined to achieve the following:

    a. Interface with other federal agency platforms to facilitate functions such as reserve mobilization, comparable performance assessment, and mission-directed rapid reassignment among federal military and nonmilitary clinical facilities;

    b. Include meaningful, relevant, supportive clinical data;

    c. Facilitate timely individual updates for essential data or information fields, such as medical license renewal and continuing medical education content and credit hours; and

    d. Offer programmed and ad hoc capabilities for generating reports so that various levels of oversight and management can better manage personnel.

4. CCQAS should be tested within a TRICARE region to facilitate better and more comparable credentials review and appointment procedures between the Managed Care Support Contract (MCSC) system and the direct care system.

History and Overview

Before 1985, military physicians were not required to have a medical license to practice in the military health system. This disparity between some military physicians and their civilian counterparts was highlighted in an unfavorable review in *Reader's Digest* magazine in 1985. In response to adverse press and congressional concern, OASD(HA) promulgated DoD Directive 6025.6, "Licensure of DoD Healthcare Providers," on July 18, 1985. This Directive established that all physicians—uniformed, civil service, or contract—practicing in military facilities must have and retain at least one valid, unrestricted, state medical license as a condition for their practice in the Military Health System (MHS).

The Directive also established a phase-in period for physicians who needed to obtain a license, which allowed them three years (until 1988) to complete the involved and variable process of application, testing, approval, and issuance. The Directive did not specify or exclude any state or licensing jurisdiction, nor did it obligate physicians who were assigned in the continental United States to have a license in the state of their current assignment.

In 1997, a series of articles by the Cox News Service revealed that the state of Oklahoma offered a special medical license, created for and limited to active duty military physicians, that had a lower set of requirements than the standard license required of practitioners practicing in the state. The articles implied that the general licensing standards for military physicians were lower than the standards for their civilian counterparts. These factors prompted an intense review by the Medical Departments of each Service of the licensure requirements and the licensure status of all physicians working in military facilities worldwide.

Army

At the time of the review, the Army Medical Department found that 8 of its 4,621 active duty military physicians had their medical license in question. These physicians were immediately placed under formal supervision and additional oversight. At the time of this Panel's briefing in November 1999, two of these physicians had been allowed to retire, four were pending retirement, one was awaiting examination results that were expected to allow receipt of an unrestricted state medical license, and one had applied to sit for a licensing examination. As of October 23, 2000, all but two were out of the Army. These two are in nonpatient care positions and in the process of retiring. (One is on terminal leave and the other is serving in an administrative position until he retires.)

All other physicians who were unlicensed were either in training (not yet eligible for a license) or newly eligible and proceeding through the licensure process in a timely fashion—and working under supervision.

Navy

The Navy found that 7 of its 3,900 active duty military physicians were licensed under the special Oklahoma license. These physicians were immediately placed under additional supervision and oversight. At the time of the Panel's briefing, five of the seven physicians had been allowed to retire, and the two remaining were assigned to administrative duties with no clinical practice component. One of these was about to undergo a show-cause hearing for involuntary separation, and the other was attempting to pass qualifying examinations. As of October 23, 2000, all but one were out of the Navy. The remaining physician is in a nonpatient care position and has litigation pending against the DoD on this issue.

All other physicians who were unlicensed were either in training (not yet eligible for a license) or newly eligible and proceeding through the licensure process in a timely fashion—and working under supervision.

Air Force

The Air Force found that 6 of 4,594 active duty military physicians were licensed under the special Oklahoma license. A process of supervision and oversight was immediately instituted. At the time of the Panel's briefing, four had been allowed to retire, one was on appellate leave following a court martial conviction for offenses unrelated to medical practice, and one was under an administrative discharge process. As of October 23, 2000, all were out of the Air Force.

All other physicians who were unlicensed were either in training (not yet eligible for a license) or newly eligible and proceeding through the licensure process in a timely fashion—and working under supervision.

Assessment and Concerns

The intensive review undertaken after the news series did establish that there was an option for a medical license for military physicians through the state of Oklahoma that was not previously recognized and that in national equivalency did not meet the "current, valid, unrestricted" intent of the DoD Directive. The series also prompted a thorough evaluation of medical board licensing requirements by states and other jurisdictions. The requirements considered included specific key credentials, regularity of performance reassessments of physicians by the licensing boards and information used for that purpose, specific compliance and educational requirements, various policy issues, and pertinent legislation and rule making.

Finally, the series stimulated an examination of the role or purpose of licensure. Aside from its commercial regulatory function, medical licensure by a state or other jurisdiction has come to serve as the primary mechanism for identifying and enforcing compliance with minimal standards (requirements) of practice. Its purpose is to protect a defined population from unqualified, incompetent, or unscrupulous practitioners. Early requirements were relatively simple, such as graduation from medical school and completion of an internship (a short, supervised practice experience) with very little if any reassessment needed for license renewals. Licensing jurisdictions vary greatly, but in recent years some jurisdictions have tightened and refined mechanisms, including requirements for longer periods of training—two or even three years of initial supervised training, data sharing among national databases (e.g., the Federation of State Medical Boards repository of adverse licensing actions taken by medical boards, and the National Practitioner Data Bank of adverse actions and liability settlements), and specific continuing medical education.

Especially for physicians practicing totally within military facilities (i.e., no privileges in a nonmilitary facility), it is debatable whether the ongoing oversight provided through the maintenance of a current valid, unrestricted civilian state license alone can be adequate, even though it is an accepted national standard. That is why the direct supervision and oversight of healthcare professionals working within an MHS facility, through the credentialing and privileging processes required by the DoD Directive (in turn driven by organizational accreditation standards), is also essential.

In addition, some specific concerns of a practical nature were noted to be of national scope (not limited to the military or specific jurisdiction), and these are not yet resolved. They include, for example:

- Redundancies and inefficiencies in "prime source" verification of credentials (such as

graduation from medical school or successful completion of postgraduate training, e.g., a residency in surgery) that prevent completion of appointment and privileging (defining a scope of authorized practice pertinent to an accountable entity) in a reasonable time;

- Capabilities to readily generate essential credentials, appointment, and privilege information needed to facilitate the deployment of physicians and their rapid reassignment to a variety of facilities to meet various mission contingencies such as disaster response;

- Timeliness in building into the system significant, readily obtainable knowledge (such as adverse licensing board actions), which now is dependent on relatively infrequent data tape updates, biannual periods of reassessment, and so on; and

- Mechanisms to obtain current, meaningful, practice assessment data and information, evaluate it, and convert the determinations into useful credentials over time.

Panel Deliberations

The Panel was briefed on the above events and concerns. It reviewed in detail the studies performed by the three Service Medical Departments and other related material. The Panel carefully examined the issues that were clarified from various perspectives, including public accountability, quality and safety management, military and civilian process comparisons, and environmental trends. Interviews with military treatment facility (MTF) Commanders conducted as part of various site visits (see Chapter VI) suggested that the material and views presented in the briefings and supportive materials were comprehensive and valid.

Of special significance was the Panel's consideration of the CCQAS, a secure database initially developed by the Navy Medical Department and gradually modified and now implemented worldwide by all three Services. It provides powerful automation support to the management of credentials and additional pertinent material, as well as related actions. (This initiative is similar to the Veterans Administration Professional Review Program [VETPRO], which has similar goals and is reaching a phase of pilot testing and subsequent refinement based on early experience.)

The Panel recognizes that credentials management is increasingly necessary for all licensed, certified, and registered healthcare personnel. Licensing, certifying, and registering entities have various monitoring and reporting obligations that must be fulfilled by the Services. The refinement of CCQAS should support these requirements.

The Panel approved the allocation of $750,000 to evolve the CCQAS platform further because in concept, content, and function it can continue to strengthen credentials management for physicians and other healthcare personnel working in military facilities. Earlier funding for CCQAS was used for refinement and initial development of the program to achieve a Web-based application, which will include, in addition to the credentials module, a malpractice/adverse actions module and a central database that will allow aggregation of the data. An additional $800,000 from TMA was put in place during September 2000 to complete development of the Web-based application for deployment in July 2001.

Panel Conclusions

1. The Cox News Service articles that focused on a special Oklahoma medical license for military physicians did identify a valid deficiency in

implementation of policy involving a small subset of military physicians.

2. Once the deficiency was understood, the response of the DoD and the Services to these articles was appropriate: addressing and managing the physicians involved, confirming the licensure status of all physicians, and conducting a thorough review of policy and related process.

3. The Panel understands that there is still great variation among requirements and processes implemented by states to control the issuance and renewal of physician licenses, although some convergence and improvement have been noted. Possession of a state license, while essential, cannot alone fully provide the protections that a dynamic quality management program, as promulgated by DoD policy, provides.

4. The direct care system's policies and processes for managing physician credentials and privileging, and for enabling their accountability and providing oversight, are at least as stringent as those used for their civilian counterparts.

5. The robust quality management program of the future must evolve an automated capability, including performance data, to support processes and decisions related to credentials management, competency assessment, and staff appointments, reappointments, and privileging for all appropriate healthcare professionals.

Panel Recommendations

1. The current direct care system licensure policy promulgated by DoD Directive should be continued within the context of a dynamic, quality management program that is increasingly based on performance data.

2. The Office of the Assistant Secretary of Defense for Health Affairs (OASD [HA]) must continue to monitor state legislative initiatives for licensure of healthcare professionals and work with national entities engaged in efforts to achieve uniformity of requirements, processes, assessment methodologies, and results.

3. The Centralized Credentials Quality Assurance System (CCQAS), the automation platform for credentials management in the direct care system, should be aggressively refined to achieve the following:

    a. Interface with other federal agency platforms to facilitate functions such as reserve mobilization, comparable performance assessment, and mission-directed rapid reassignment among federal military and nonmilitary clinical facilities;

    b. Include meaningful, relevant, supportive clinical data;

    c. Facilitate timely individual updates for essential data or information fields, such as medical license renewal and continuing medical education content and credit hours; and

    d. Offer programmed and ad hoc capabilities for generating reports so that various levels of oversight and management can better manage personnel.

4. CCQAS should be tested within a TRICARE region to facilitate better and more comparable credentials review and appointment procedures between the Managed Care Support Contract (MCSC) system and the direct care system.

CHAPTER V
Reestablish the Quality Management Report (QMR) to Aid in Early Identification of Compliance Problems

Panel Recommendations

1. Reestablish and improve the Quality Management Report (QMR) as a:

    - Comprehensive information product for communicating with and educating leadership within Congress, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]), TRICARE Management Activity (TMA), the Services, and the Military Treatment Facilities (MTFs) on the status of quality in the Military Health System (MHS);

    - Framework to position and bridge essential components of the proactive MHS Quality Management Program; and

    - Vehicle to facilitate meaningful, specific comparisons among the Services, the federal agencies, and the civilian healthcare sector, especially in the risk management and patient safety arena.

2. Continue to refine the TRICARE Operations Performance Statement (TOPS) program to achieve better automated data support, better data utility for the operational levels of MTF and Regional Lead Agents (senior regional TRICARE administrative function), improved data quality, and better reflection of personnel resources.

3. Promulgate a definition of "quality" concerning MHS and TRICARE healthcare and related services that can be used to identify and position data and automation support initiatives in the future. Incorporate the definition into DoD Directive 6025.13, "Clinical Quality Management Program in the Military Healthcare System."

History and Overview of the Quality Management Report

The QMR evolved from the Medical Quality Assurance Program (MQAP) Report, first produced in 1989 to provide an annual narrative summary report about basic aspects of quality in the MHS. The MQAP Report was constructed from data and information pertinent to specific topics, prepared in a uniform fashion, and contributed by and aggregated from the Services. The content outline for material provided by the Services to build the MQAP Report for calendar year 1989 is reproduced and provided as Appendix V.1 at the end of this chapter.

The goal of the QMR and the MQAP Report was to provide a comprehensive framework to position information needed to monitor and improve quality, identify areas needing development, stimulate uniform metrics, integrate analysis, and facilitate meaningful comparisons among the Services, the federal agencies, and the civilian healthcare sector.

In the early 1990s, the QMR was identified as a component of the National Quality Management Program (NQMP). It continued with a focus on quality, but it also provided a limited amount of information on cost, access, and medical readiness. Some areas of quality it addressed were refined or expanded, including accreditation, credentials, the National Practitioner Data Bank (NPDB), the Defense Practitioner Data Bank (DPDB), external review of care (product lines, standard of care determinations, early performance measurements), and utilization management. Data for the QMR were gathered largely from departments within OASD(HA), TMA, the Services, the NPDB, and the Armed Forces Institute of Pathology (AFIP)/ Department of Legal Medicine (DLM).

The QMR documented changes, problems, and improvements in the MHS for the previous year. Although it did allow some comparisons within the military and between the military and civilian sectors (e.g., accreditation standards compliance), the report was largely centered on the direct care (military) system as opposed to the civilian care system component of the MHS. The QMR was used as a reference document for senior leadership within the OASD(HA), TMA, the Surgeons General Offices (SGOs), and Congress. Approximately 150 copies are sent out to each of the SGOs for distribution within their respective Services. (Completed reports are available on the TMA Web site at www.tricare.osd.mil).

The 1995 QMR was the last such report issued (see Appendix V.2 for the outline); by that time the MHS report card now known as TOPS (TRICARE Operational Performance Statement; see Appendix V.3) had been developed. Ironically, the QMR was viewed as having served its purpose and was considered redundant to the MHS report card. However, following the Cox News Service articles in October 1997, senior leadership decided to bring it back as one of the Quality Initiatives. A QMR on 1996 data was then developed in 1998 and published and distributed in January 1999.

Concerns Regarding the DoD Quality Management Report

Concerns surrounding the QMR relate to timeliness, usefulness (value added given the work required), and need (given the existence of TOPS). The major differences between the two reports involve timelines and format. The QMR is an annual report, with a lag time of approximately 12 months, formatted in a narrative style with graphs and tables. TOPS is a quarterly report, with a lag time of approximately three months, formatted in a report card style with qualified and quantified metrics. Substantial overlap has been noted between certain content categories and data addressed by both the QMR and TOPS (e.g., patient satisfaction, waiting times, satisfaction with access, malpractice data, preventable admissions for diabetes and asthma, regional utilization rates for bed days per 1,000 beneficiaries, compliance scores with Joint Commission on Accreditation of

Healthcare Organizations [JCAHO] standards, and dental wellness/readiness).

Panel Deliberations

Representatives of the QMR and TOPS briefed the Panel extensively at Panel meetings in October 1999 and March 2000. Panel deliberations encompassed the issues of timeliness, usefulness (value added), and need, as well as the purpose and goals of both products. The Panel reviewed the content and thrust of the Cox News Service articles in the context of information provided in the QMR as well as in the TOPS reports. The Panel also considered the automation and data infrastructure available or being developed to provide TOPS data, some related automation initiatives, and pertinent data quality issues.

It was troubling that neither the direct care nor the purchased care components of TRICARE had promulgated or used a definition of quality as a litmus test to focus and assess the impact or progress of supportive quality management data initiatives.

Panel members discussed and confirmed the need for an annual QMR as a vehicle for communicating and educating leadership within Congress, OASD(HA), TMA, the Services, and the MTFs about quality and related concerns within the MHS. Although members agreed that the report would not necessarily aid in early identification of compliance problems or drive change within the MHS, it was seen as an essential framework to focus and bridge or integrate various quality management and related data initiatives. The QMR must provide a meaningful system-level depiction of quality and use national benchmarks with specific comparative metrics. For areas not yet addressable through automated data infrastructure, the QMR report must provide a comprehensive assessment of quality using special reports, consensus input, and interpretive narrative to assess and depict significant activities in total quality management.

The Panel thought that the QMR is an excellent way to bridge "science to art" or "evidence to wisdom" in selected areas of clinical outcomes, practice guidelines, and satisfaction survey products.

In summarizing its specific consideration of the TOPS program, the Panel concluded that the TOPS data are a representation of simple data elements, without pretense of linkage on specific variables—resourcing, readiness issues, and possibly others—which are confounders of the data. This lack of control inhibits regression analysis, which would define the contributions of each variable to the observed data. At best, the TOPS is a broad topographical portrayal of system performance for analysis by senior leadership. Its usefulness at the MTF and regional TRICARE levels remains conjectural. Furthermore, the lack of unified command and control of TRICARE regional MTF facilities and resources interferes with, and possibly prohibits, effective integrated regional management and thus the utility of TOPS and other quality performance data.

Panel Conclusions

1. The QMR provides essential information basic to depiction and assessment of MHS quality not now available from data-based automated programs.

2. TOPS does not address operational support at MTF or TRICARE regional levels, data quality issues, or functional resource dependencies.

3. A definition of "quality" for MHS clinical healthcare and related services would serve as a useful yardstick for positioning or assessing automation initiatives, analyses, and reports in the future.

Panel Recommendations

1. Reestablish and improve the Quality Management Report (QMR) as a:

   - Comprehensive information product necessary for communicating with and educating leadership within Congress, the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]), TRICARE Management Activity (TMA), the Services, and the Military Treatment Facilities (MTFs) on the status of quality in the Military Health System (MHS);

   - Framework to position and bridge essential components of the proactive MHS quality management program; and

   - Vehicle to facilitate meaningful, specific comparisons among the Services, the federal agencies, and the civilian healthcare sector, especially in the risk management and patient safety arena.

2. Continue to refine the TRICARE Operations Performance Statement (TOPS) program to achieve better automated data support, better data utility for the operational levels of MTF and Regional Lead Agents (senior regional TRICARE administrative function), improved data quality, and better reflection of personnel resources.

3. Promulgate a definition of "quality" concerning MHS and TRICARE healthcare and related services that can be used to identify and position data and automation support initiatives in the future. Incorporate the definition into DoD Directive 6025.13, "Clinical Quality Management Program in the Military Healthcare System."

APPENDIX V.1

Outline (Format) for OASD(HA) Annual Quality Assurance (QA) Report—CY 1989

I. Mission
- A. Patient Care
  1. Numbers
  2. Age / Sex / Status / Distribution
- B. Training
- C. Research and Development

II. Resources
- A. Credentialed / Privileged Staff (Military, Civilian)
  1. Percent board eligible / board certified
  2. Licensure status report
  3. Adverse privileging actions
- B. Other Personnel (Military, Civilian)
  1. Administrative / ancillary support
  2. Nursing personnel
  3. Medical records personnel
  4. QA personnel
  5. Staffing patterns
     a. Assigned / authorized by title
     b. Assigned / recognized by title
     c. Civilian contract
- C. Facilities
  1. List by category
  2. Accreditation status—JCAHO
  3. Other accreditations—CAP, AABB, CARF, etc.
- D. Equipment
  1. Automation (AQCESS, CHCS—hardware, software)
  2. MEDCASE funding
- E. Managed Health Care
  1. CHAMPUS
  2. CRI Quality Management / Utilization Management Program
  3. Contract clinics (NAVCARE / PRIMUS)
  4. USTFs

III. Productivity
- A. Navy Health Care Planning Matrix (prepared by Director, Naval Medicine / Surgeon General and Commander, Naval Medical Command)

IV. Outcomes / Results

A. Personnel Training
   1. GME / GDE report
   2. Nonphysician training programs, output
   3. Other

B. Patient Contact
   1. Patient-focused instructional programs
   2. Patient satisfaction survey results
   3. Patient inquiries and complaints
   4. Congressional-Service liaison office experience

C. Reports / Studies
   1. Accessibility of services
   2. Composite Service IG findings
   3. Risk Management—Service report of claims
   4. Outcome rates
   5. Civilian External Peer Review Program
   6. Results of other studies pertinent to QA

V. Summary Statement / Narrative Comment

A. Mission Changes
B. New Programs / Initiatives
C. Major Milestones / Goals
D. Impacts on Care / Problems / Concerns
E. Recommendations

APPENDIX V.2

DoD Quality Management Report (QMR) Outline (c. 1995)

I. Executive Summary

II. Narrative Report And Recommendations

A. Quality
   1. Introduction
   2. Medical Readiness
   3. Accreditation
   4. Credentials and Privileges
   5. Licensure
   6. Board Certification
   7. National Practitioner Data Bank
   8. Defense Practitioner Data Bank
   9. Special Studies
   10. Utilization Management Oversight

B. Access

C. Cost

D. Recommendations

E. Appendix: Status Report of Recommendations from Prior QMR

F. Appendix: DoD QM Indicators

G. List of Acronyms

H. List of Figures, Tables, and Charts

APPENDIX V.3

Tricare Operational Performance Statement (TOPS)

Tricare Management Activity's Operational Performance Statement (TOPS)

Perspective	Number	Performance Measure	TOPS Benchmark
Employer	E1	Active Duty Mental Health Status Score Below 34.42	< = 6%
	E2	Active Duty Physical Health Status Score Below 42.34	< = 11%
	E3	Active Duty Temporarily Disqualified for Deployment—Medical Profile	< = 2%
	E4	Active Duty Temporarily Disqualified for Deployment—Dental Class 3 or 4	< = 5%
	E5	Rating of All Health Care	> = 70%
	E6	Getting Needed Care	> = 73%
	E7	Rating of Health Plan	> = 57%
	E8A	Active Duty Preventable Admission Rates	< = 2.3 RWPs
	E8B	Active Duty Family Member Preventable Admission Rates	< = 3.8 RWPs
	E9	Dental Wellness	TBD
	E10	Active Duty Family Member Mental Health Status Score Below 34.42	< = 8%
	E11	Active Duty Family Member Physical Health Status Below 42.34	< = 14%
	E12	Percentage of DoD GME Grads Who Pass Spec Boards on First Try	> = 95%
	E13A1	Match Between Surgeon Billets and Inventory	> = 95%
	E135A2	Match Between Nonsurgical Medical Officer Billets and Inventory	> = 95%
	E13B	Match Between Dental Corps Billets and Inventory	> = 95%
	E13C	Match Between Nurse Corps Billets and Inventory	> = 95%
	E13D	Match Between Medical Service Corps Billets and Inventory	> = 95%
	E13E	Match Between Allied Scientist Billets and Inventory	> = 95%
Perspective	**Number**	**Performance Measure**	**TOPS Benchmark**
Health Plan	H1	Rating of All Health Care—Military PCM-Based Healthcare	71%
	H2	Rating of All Health Care—Network PCM-Based Healthcare	71%
	H3	Rating of Personal Physician—Military PCM-Based Healthcare	72%
	H4	Rating of Personal Physician—Network PCM-Based Healthcare	72%
	H5	Getting Needed Care—Military PCM-Based Healthcare	73%
	H6	Getting Needed Care—Network PCM-Based Healthcare	73%
	H7	Rating of Health Plan—Military PCM-Based Healthcare	59%
	H8	Rating of Health Plan—Network PCM-Based Healthcare	59%

	H9	Customer Service Rating	55%
	H10	Claims Processing Rating	78%
	H11	Dispositions Per 1,000 Prime Enrollee—Civilian PCM Enrolled	36.8
	H12	Bed Days Per 1,000 Prime Enrollee—Civilian PCM Enrolled	144.1
	H13	Dispositions Per 1,000 Prime Enrollee—Military Primary Care Manager Enrolled	34.6
	H14	Bed Days Per 1,000 Prime Enrollee—Military Primary Care Manager Enrolled	130.5
	H15	Claims Processed Within 30 Days	> = 95%
	H16	Incentives Awarded to MCSC	$0
	H17	MCSC Toll-Free Phone System All Lines Busy Rate	< = 20%
	H18	MCSC Percentage of Calls Answered Within 120 Seconds	> = 90%
	H19	Beneficiary Grievance Per 1,000 Enrollees	TBD
	H20	Beneficiary Appeals Per 1,000 Claims	TBD
Perspective	**Number**	**Performance Measure**	**TOPS Benchmark**
Health Plan	H21	Preventable Admission Rates for Active Duty Personnel	
	H21A	Chronic Obstructive Pulmonary Disease	0.03
	H21B	Bacterial Pneumonia	0.10
	H21C	Asthma	0.02
	H21D	Congestive Heart Failure	0.05
	H21E	Angina	0.03
	H21F	Cellulitis	0.07
	H21G	Diabetes	0.05
	H21H	Gastroenteritis	0.03
	H21I	Kidney/Urinary Infections	0.02
Perspective	**Number**	**Performance Measure**	**TOPS Benchmark**
Health Plan	H22	Preventable Admission Rates for Non-Active Duty Prime Enrollees	
	H22A	Chronic Obstructive Pulmonary Disease	0.17
	H22B	Bacterial Pneumonia	0.30
	H22C	Asthma	0.07
	H22D	Congestive Heart Failure	0.36
	H22E	Angina	0.14
	H22F	Cellulitis	0.08
	H22G	Diabetes	0.12
	H22H	Gastroenteritis	0.06
	H22I	Kidney/Urinary Infections	0.11

Perspective	Number	Performance Measure	TOPS Benchmark
MTF	M1	Medical Readiness Trained and Certified (Centralized Credentials Quality Assurance System [CCQAS])	90%
	M2	MTF Satisfaction with Quality of Healthcare at the MTF	88%
	M3	MTF Satisfaction with Interpersonal Relations at the MTF	84%
	M4	Wait Time at Appointment at MTF	88%
	M5	MTF Prime Enrollees Meeting Appointment Waiting Standards	88%
	M6A	Satisfaction with Access to Providers (All Users)	N/A
	M6B	MTF Prime Enrollee Satisfaction with Access to Providers	79%
	M7A	Satisfaction with Access to System Resources (All Users)	N/A
	M7B	MTF Prime Enrollee Satisfaction with Access to System Resources	80%
	M8	MTF Prime Enrollee Propensity to Re-enroll	84%
	M9	Overall Satisfaction with MTF Clinic Visit	86%
	M10	Overall Satisfaction with Medical Care at MTF	87%
	M11	JCAHO Grid Scores	92%
	M12	M12: Number of Malpractice Claims Filed Per 100 Physicians	< 15.8
	M13	M13: Number of Malpractice Cases Paid Per 100 Physicians	< 3.2
	M14	M14: Actual versus Target Enrollment*	TBD

Perspective	Number	Performance Measure	TOPS Benchmark
DTF	D1	Patient Satisfaction with Quality of Oral Healthcare at the Dental Treatment Facility	88%
	D2	Patient Satisfaction with Interpersonal Relations at the Dental Treatment Facility	83.50%
	D3	Wait Time at Appointment at Dental Treatment Facility	87.50%
	D4	Wait Time for Appointment at Dental Treatment Facility	87.50%
	D5	Satisfaction with Access to Dental Treatment Facility Providers	78.50%
	D6	Patient Propensity to Return to Dental Treatment Facility for Care	83.50%
	D7	Overall Satisfaction with Dental Treatment Facility	85.50%
	D8	Overall Satisfaction with Dental Care Received at Dental Treatment Facility Visit	86.50%

Perspective	Number	Performance Measure	TOPS Benchmark
Data Quality	DQ1	SIDR Timeliness	TBD
	DQ2	SADR Completeness	TBD
	DQ3	MEPRS Completeness	41.67

CHAPTER VI
Improve Communications with Beneficiaries to Provide Comprehensive and Objective Information on the Quality of Care Being Provided

Panel Recommendations

1. Maintain and continue to improve the Military Treatment Facility (MTF) report cards so that they provide meaningful information to beneficiaries. Further, through communications with beneficiaries, continue to identify those markers of quality of care that the beneficiaries determine should be measured on the MTF report card.

2. Maintain and continue to improve the provider directories so that they furnish meaningful information to beneficiaries.

3. Maintain and continue to improve the Healthcare Consumer Councils (HCCs) so that they provide a forum for a meaningful dialogue to connect beneficiaries with both the providers and the administrators of their healthcare. Tracking and resolution of identified issues should be a significant agenda item.

4. Make the benefit and benefit administration uniform across the TRICARE spectrum, including the direct care and purchased care components.

5. Continue to develop initiatives to improve communication with beneficiaries and to enhance their education on healthcare quality issues.

History and Overview

On January 8, 1998, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) published "Improving Access and Quality in the Military Health System (MHS)," regarding its policy for improving communications with beneficiaries. The policy identified the following three mechanisms:

- An MTF report card for public review would be prominently posted at several locations throughout each MTF worldwide.

- A Healthcare Provider Directory would be developed, maintained, and routinely updated by each MTF.

- A Healthcare Consumer Council (HCC)/ Consortium would be coordinated and routinely scheduled by each MTF Commander to provide a forum for meaningful dialogue among providers, administrators, and beneficiaries.

MTF Report Card

The purpose of the MTF report card is to inform beneficiaries of the MTF's performance in at least four critical areas:

- Wait time access for major services—Wait times were defined as the number of days a patient would expect to wait before being seen for a routine appointment by a healthcare provider.

- Patient satisfaction—Patient satisfaction results were to be taken from the Department of Defense (DoD) Patient Satisfaction Survey.

- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) summary grid score—A brief explanation of JCAHO would clarify the role and function of the organization and help the reader understand the meaning and implications of the JCAHO survey scores.

- Four grid score elements from the JCAHO survey—An explanation of what each of the four elements in the JCAHO survey grid means was to be included. All hospitals and clinics were required to post the MTF report card in a conspicuous place, and the information was to be updated as more current data became available. The four survey grid elements were:
  - Credentialing,
  - Assessing provider/staff competence,
  - Infection control, and
  - Nursing care.

Healthcare Provider Directory

The purpose of the Healthcare Provider Directory was to give beneficiaries information about the healthcare providers who serve as primary care managers and specialists in each MTF. At a minimum, the handbook would offer the following information on each provider:

- Name,

- Degree,

- Dates of graduation from medical school and residency,

- Board certification,

- Clinic assignment and phone number, and

- Primary state of licensure.

The directory would also list civilian healthcare providers within the MTF and be updated annually and made available to all TRICARE prime enrollees.

Healthcare Consumer Council

An HCC at each facility would be chaired by the MTF Commander and consist of members who reflected the beneficiary population served by the MTF. Meetings would occur quarterly, and minutes would be generated. Priority would be placed on issues and concerns of enlisted personnel. Given this charter, the primary purpose of the HCC was to provide an open forum for:

- Sharing MTF organizational and healthcare delivery information,

- Airing beneficiary-related concerns, and

- Participating in discussion related to major policy decisions affecting the MTF.

Fact Finding by the Members of the Panel

The members of the Panel decided that the best way to gather information about MTF compliance with the three mechanisms listed above, as well as the other eight Quality Initiatives examined by the Panel, was to visit a variety of MTFs. These visits also provided an opportunity for the Panel members to speak with the MTF Commanders, Quality Management Directors, HCCs, medical staff, and beneficiaries. Plans were made for site visits to Army, Navy, Marine, and Air Force sites on both coasts, a DoD/Department of Veterans Affairs joint venture facility, and a Uniformed Services Treatment Facility (USTF).

Medical Treatment Facility Site Visits

At the outset, the Panel made it exceedingly clear to MTF leadership that the site visits were not for attribution and were only for the purpose of gathering information. To that end, the TRICARE Management Activity (TMA) staff enlisted the support of the appropriate Regional Lead Agencies and MTF Commanders to provide a meaningful experience for the Panel. In keeping with proper military protocol, TMA staff worked with each MTF Commander to ensure that the local Line Commander was given advance notice that the Panel would be in the area and that its Chairman was available for a courtesy call if the Line Commander so desired.

To make the best use of the time allotted for site visit investigations, Panel members developed a detailed list of questions for MTF personnel (see Appendix VI.1). These questions were provided 30 days before the Panel members arrived, and written responses were requested so that each site visit would have a permanent record. MTF Commanders were given the opportunity to request clarification of the questions from TMA staff before each site visit. The MTF Commanders were also given the names of the Panel members and instructions for finding their biographies on the Healthcare Quality Initiatives Review Panel Web site.

The MTFs identified by the Panel for visits were:

- Puget Sound
  - Madigan Army Medical Center, Tacoma, WA
  - Naval Hospital, Bremerton, WA
  - PACMED–USPHS/Family Health Center, Seattle, WA

- Tidewater/Quantico
  - 1st Medical Group, Langley AFB, VA
  - Naval Medical Center, Portsmouth, VA
  - Naval Medical Clinic, MCCDC, Quantico, VA

- Albuquerque, MTF/Veterans Affairs (VA) Cooperation
  - 377th Medical Group Clinic, Albuquerque, NM
  - Veterans Affairs Hospital, Albuquerque, NM

During each site visit, the Panel met with the MTF HCCs, the Quality Improvement Directors, the MTF Commanders, and provider groups, as detailed below.

Meet with the MTF Healthcare Consumer Councils

Each of the MTFs visited had developed an HCC, and in each case the Panel members had an opportunity to meet with the council. Because these HCCs are made up of volunteers, and because the meetings were held during normal business hours, participation by the council members was somewhat sparse, except at Quantico, VA. Irrespective of council size or location throughout the country, the comments and concerns voiced were noticeably consistent, and they were also consistent with the data regularly gathered from Patient Satisfaction Surveys. In sum, the

beneficiaries consistently expressed the following views:

- The quality of care administered at the MTFs was excellent.
- The triple option program (TRICARE Prime, Extra, Standard) is often confusing.
- Getting access to care at the MTF was often difficult because of the appointment systems in place.
- The MTF providers were both well trained and genuinely concerned about the welfare of their patients.
- Many of those members who were nearing their 65th birthday expressed concern about the loss of their healthcare benefit that was "promised for life" when they entered the Service. It is not clear what is being done to ensure access to care and pharmacy benefits in TRICARE for Medicare-eligible beneficiaries.
- Many beneficiaries said they did not know who to call when a question arose about getting access to the network providers or how to deal with bills from both network and non-network providers.
- Many senior enlisted members noted that collection agencies had contacted their junior enlisted personnel, in many cases, not because the members could not pay their bills but rather because of their "confusion about the TRICARE program—what they needed to pay for and what was covered by the benefit."
- The larger MTFs had more complaints about continuity of care breaking down because multiple clinical departments had difficulty communicating effectively with the primary care provider. In the smaller MTFs, this did not seem to be as big a problem.
- Metrics are not currently available for beneficiaries to assess quality of care in the managed care networks.
- MTF providers are developing specialty care programs based on the needs of local patient populations (e.g., education and self-help treatment programs have been developed for patients with diabetes or asthma, patients at risk for cardiovascular disease, patients with high cholesterol, and patients with breast cancer). These population-centered health programs reflect the MTFs' general commitment to prevention and education as a means of improving the quality of life for their beneficiaries.
- Overall, patient satisfaction seemed highest in geographic regions where the TRICARE program was more mature, and patient dissatisfaction was highest where the TRICARE program had been recently put in place. These findings are consistent with the data collected and published by the DoD in the Patient Satisfaction Survey; the survey results are used to develop the MTF report cards.

Meet with the Quality Improvement Directors

The Quality Improvement Director of each MTF had a listing of several programs that had been initiated as a direct result of patient comments and perceived patient needs. These programs encompassed specialty care for diabetics, mothers and infants, asthmatics, and so on. Prevention was consistently the thrust of these quality improvement programs, with an emphasis on reducing patients' visits to the MTF through education and self-care.

Meet with the MTF Commanders

Each MTF Commander allotted at least 60 minutes to speak candidly and directly to the Panel members. Although these meetings were not

recorded, several themes were repeated throughout the six MTF meetings:

- Additional personnel are needed to provide patients with quality care and to meet the military and quality reporting requirements of each MTF.

- Funds are needed for programs that will attract and treat patients in the MTFs and therefore avoid the costly leakage of patients being referred to the contract network providers.

- Clear and consistent direction is needed from TMA on many future initiatives—such as Primary Care Manager by Name (PCMBN), Revised Financing, TRICARE 3.0 Contract, Individual Case Management—and other major policy issues.

Meet with Provider Groups

The provider groups echoed many of the concerns cited by the MTF Commanders. Additional personnel, additional funding for specialty programs, and the time requirements that would follow the implementation of PCMBN were all of paramount concern to the providers. They basically wanted assurances that they would have the properly trained personnel and the financial resources to provide quality care to their patients.

Panel Deliberations

During subsequent meetings, the Panel deliberated on many of the issues raised during the site visits. Significant topics included the following:

MTF Report Cards

- **How is a report card reported to beneficiaries?**

OASD(HA) requires that each MTF report card be posted in at least one prominent place throughout the MTF. Although the MTF staff were quick to point out where the report cards were located, when Panel members asked several patients walking in the vicinity of the report cards about their location, the patients were either unaware of their posting or had little interest in what information was actually posted.

- **How is a report card updated?**

Per the OASD(HA) requirement, the report cards were updated as soon as current data became available. Most staff felt that monthly reporting would be more appropriate, even though the patient feedback section would be difficult to aggregate on such a short turnaround schedule. None of the data reported on any of the six MTF report cards was older than six months. The JCAHO grid elements that depicted Credentialing, Assessing Provider/ Staff Competence, Infection Control, and Nursing Care were prominently displayed on the MTF report cards.

Healthcare Provider Directory

Each MTF dealt with the Provider Directory quite differently. Each MTF had at least one copy available per facility. The consistent complaint centered on the time and expense of keeping a hard-copy directory properly updated. Many facilities were working on developing an electronic directory that could be made available at a computer workstation or on the MTF's Web site. All MTF Commanders agreed with the need to maintain the directory, but they likewise lamented the time and costs associated with compliance with this standard.

Public Correspondence with the Panel

The Panel established a Web site in late October 1999 as a forum to disseminate information to the public on a continuous and timely basis. The www.hqirp.gov site published a mailing address for beneficiaries to send written comments about the TRICARE benefit and the quality of care received

in the MTFs as well as throughout the TRICARE network of contracted providers.

Through the efforts of the DoD information clearinghouse and the TRICARE Communications & Customer Services (C&CS) Directorate, the Panel's Web site address has been posted in numerous military publications related to beneficiaries. The variety of locations from which the Panel has received comments is evidence that it has had worldwide exposure. In keeping with the Panel's request from the July 2000 meeting, the written comments received are individually assessed for content and aggregated by general category of comment. The Panel received 16 letters between November 1999 and July 2000. A detailed synopsis of these beneficiary concerns can be found in Appendix VI.2.

Correspondence with TRICARE Management Activity (TMA)

Through its C&CS Directorate, TMA maintains an extensively detailed Web site (www.tricare.osd.mil) with numerous links to the MHS and the DoD. To that end, the TRICARE Web site has been an invaluable resource for tracking incoming correspondence and contacts about beneficiary concerns. The C&CS staff keeps extensive records, aggregates the data, and creates monthly reports. The TRICARE C&CS Directorate received 7,616 inquiries and comments between January 2000 and June 2000. A detailed synopsis of the concerns expressed by beneficiaries can be found in Appendix VI.3. The Panel is concerned that issues related to access may be embedded in the categories used by TMA (listed in Appendix VI.3), and that "access" issues may thus be underreported.

Quality of Care versus Quality of Benefits

The topic of quality of care was given extensive consideration in light of beneficiaries' comments. The Panel was consistently confronted with beneficiaries' confusion about the difference between quality of care and quality of benefits. Often, the beneficiaries raised questions about not having access to a benefit that was robust enough to satisfy their personal needs. Benefit issues included:

- Lack of full and complete access to chiropractic care
- Objections to the requirement that Non-Availability Statements (NASs) be issued to TRICARE Standard and Extra beneficiaries by catchment area MTFs for elective inpatient care and all obstetrical treatment
- Feelings among members age 65 and over that not having full and complete access to care was a moral breach of contract by the government

Quality Indicators Identified by Beneficiaries

When the Panel asked the beneficiaries to comment on what they thought constituted quality care (as opposed to quality of benefit), the following themes consistently came through:

- An appointing system process that is fast, friendly, and efficient
- Clarity and consistency across all TRICARE Regions in the process to access care within the triple-option TRICARE benefit (Prime, Extra, Standard)
- Expansion of the benefit to beneficiaries 65 and older
- MTF staff who work closely with the MCSC to continually improve the coordination within the network system
- Providers who display a caring and compassionate manner

- PCMs with the ability to coordinate care with multiple providers and ancillary services
- Receiving the appropriate level of intervention from the personnel who answer the MCSC and MTF appointment lines
- Knowing that the beneficiary's PCM has been notified regarding information provided by the toll-free Nurse Help-Line to ensure continuity of care
- Printed educational materials that are clear, nontechnical, and informative
- An understanding that out-of-pocket expenses are both predictable and kept to a minimum
- A unified billing system that protects the beneficiary from the potential financial burdens associated with processing delays

Panel Conclusions

1. Site visits and other Panel considerations indicate that MTFs are displaying report cards that include the mandatory four elements.
2. Most MTFs have developed and maintain Provider Directories and are working to improve future editions. Improvements are focused on the manner or medium in which the information is made available to the beneficiary. Cost considerations and ease of updating the material have influenced many of the MTFs to develop an electronic record that is accessed at hospital-based computer terminals, instead of printing multiple hard-copy volumes, which are subject to vandalism and theft.
3. Although each MTF is unique in make-up, organizational style, and interest for the beneficiaries, most MTFs have a consistent and regularly scheduled program that enables the beneficiaries to meet with the MTF Commander as well as the MTF staff members.
4. To beneficiaries, the issue of quality of healthcare cannot be separated from a discussion of access and the robustness and uniformity of healthcare benefits.
5. The frequent, ongoing changes in the organizational structure of the MHS and the TRICARE benefit are creating a communication and educational burden for both beneficiaries and providers.

Panel Recommendations

1. Maintain and continue to improve the Military Treatment Facility (MTF) report cards so that they provide meaningful information to beneficiaries. Further, through communications with beneficiaries, continue to identify those markers of quality of care that the beneficiaries determine should be measured on the MTF report card.
2. Maintain and continue to improve the provider directories so that they furnish meaningful information to beneficiaries.
3. Maintain and continue to improve the Healthcare Consumer Councils (HCCs) so that they provide a forum for a meaningful dialogue to connect beneficiaries with both the providers and the administrators of their healthcare. Tracking and resolution of identified issues should be a significant agenda item.
4. Make the benefit and benefit administration uniform across the TRICARE spectrum, including both the direct care and purchased care components.
5. Continue to develop initiatives to improve communication with beneficiaries and to enhance their education on healthcare quality issues.

APPENDIX VI.1

Site Visit Standardized Information Sets

The Panel asked each MTF to respond to the same set of questions. The TMA staff, in collaboration with the Panel members, identified and selected the following questions for submission to the MTFs:

- **Questions for meeting with MTF Commander/hospital CEO**
  - What do you view as the biggest healthcare quality issues
    - throughout your Military Health Facility (MTF)?
    - throughout the Military Health System (MHS)?
    - and what is your organization doing about the quality issues you have identified?
  - How do you make use of your Healthcare Consumer Committee (HCC)?
    - What purpose does your HCC serve in your MTF?
  - What is your vision of the direction of healthcare quality for this MTF?
  - As the MTF Commander,
    - how long have you been in this position?
    - did you get any training in healthcare quality issues and processes before taking this position?
  - What are your significant information management/information technology (IM/IT) shortfalls?
  - What does the Line leadership expect of you and your organization?
  - What does the Medical leadership expect of you and your organization?
- **Questions for meeting with Director of Quality Services Programs and Patient Advocacy/Relations Personnel**
  - How are your practitioners being educated about the quality issues and initiatives confronting your MTF?
  - Do you provide or coordinate healthcare quality/patient relations training for your hospital staff?
  - How would a quality or quality-process issue identified by a staff member or beneficiary be brought to the attention of your MTF leaders?
    - How do you track, trend, and report quality issues?
    - How do you cycle these issues into system change?
    - What quality initiatives are you currently tracking?
  - Are you engaged in or planning any healthcare quality initiatives in conjunction with other MTFs, other federal facilities, or other civilian facilities?
    - Do you anticipate any future initiatives or ventures?
  - Is your laboratory accredited by the College of American Pathologists (CAP)?
  - Please describe your provider credentialing/ privileging process.

  - What is your oversight of nonprivileged providers?

- What is the licensure status of the staff members who are required to have licenses to function independently?

- What would you do about a physician whose license has lapsed?

- What is your process for dealing with a physician for whom a healthcare quality or ethics issue arose?

- What is the MTF policy or process for reporting sentinel events?

- What is the MTF policy or process for reporting adverse actions?

- Please describe your risk management process.

- Please describe what you do upon notification of a PCE (Potentially Compensable Event).

- Please describe your risk management process for claims that are settled or in which an award is made.

- Do your providers get any training in risk management?

- Does your facility maintain a MTF report card?
  - Where is it posted or displayed?
  - How often is the report card updated?
  - How do you handle questions about what the report card means?
  - What value is provided by the report card?

- Does your facility maintain an MTF Provider Directory?
  - Do you consolidate the MTF and civilian network directories?
  - How often is the Provider Directory updated?
  - How and to whom is the Provider Directory provided?
  - What value does the Provider Directory provide?

- **Questions for meeting with Command/ hospital-selected group of physicians, nurses, technicians, and administrative personnel**

  - Can you identify and describe the MTF's major quality improvement initiatives?

  - How do the quality improvement process and initiatives affect what you do?

  - Are there any quality issues or concerns that you can see at this MTF? In the system?

  - What do you see as the biggest quality issues facing your MTF? The MHS?

  - What is your connection with your local civilian network?

  - Have you received any training or education about the healthcare quality process?

- **Questions for meeting with the Healthcare Consumer Committee in executive session**

  - Describe the Committee structure, including membership strata and term length and how members are selected.

  - What issues has this Committee looked at or taken for action?

- What has changed as a result of the Committee's actions?
- Do the leaders of the MTF participate in the activities of the Committee?
- How are issues brought to the Committee?
  - What follow-up is provided on quality issues previously presented to the Committee?
- Who controls this Committee?
- Who sets the meeting agendas?
- Is this Committee useful? How? Why?
- Are the beneficiaries who use this MTF aware of this Committee?
- How are Committee meetings publicized?
- How are beneficiaries made aware of how to bring issues to this Committee?
- Can you identify and describe the MTF's major quality improvement initiatives?
- Are there any quality issues or concerns that you can see at this MTF? In the system?

- **Questions for meeting with the Healthcare Consumer Councils in open session (Public Input and Commentary)**
  - If you had a complaint about something or someone in this MTF, how would you call attention to it?
  - If you had an issue about the civilian healthcare network, how would you call attention to it?
  - Do you believe MTF leadership treats beneficiary concerns seriously? Explain.
  - Have you seen the MTF report card?
  - What are your concerns about healthcare quality
    - in this MTF?
    - in the civilian network?
    - throughout the MHS?

APPENDIX VI.2

Written Correspondence to the Healthcare Quality Initiatives Review Panel

The Panel established a Web site (www.hqirp.gov) in late October 1999 as a forum to disseminate information to the public from the Panel on a continuous and timely basis. The site published a mailing address for beneficiaries to send written comments about the TRICARE benefit and the quality of care received in the Military Treatment Facilities (MTFs) as well as throughout the TRICARE Network of contracted providers.

During this same timeframe, through the efforts of the DoD information clearinghouse and the TRICARE Communications & Customer Services (C&CS) Directorate, the address of the Panel's Web site also has been posted in numerous military beneficiary-related publications. The variety of locations from which comments were received is evidence that the Panel has had worldwide exposure. In keeping with the request made by the Panel at its July 2000 meeting, an overview of the written comments it has received has been individually assessed for content and aggregated by general category of comment. The following is an aggregated synopsis of the material received during the last nine months.

Letters received by the HQIRP from November 1999 through July 2000

Status of correspondents:	
Active Duty Member	0
Active Duty Family Member	1
Retiree	5
Retiree Family Member	4
Other	5 *
Unknown	1
Total	**16**
Beneficiary Issues:	
Access	1
Claims	4
Compliments	2
Contractor performance	1
Healthcare for life	3
Network providers	3
Out-of-pocket costs	6
Provider quality	3
Reimbursement	2
Other	5
Total	**30**

* Four of these were from DoD schools employees, who are not eligible for care in the MTF.

APPENDIX VI.3

Correspondence with TRICARE Management Activity (TMA)

TMA's Communications & Customer Services (C&CS) Directorate maintains an extensively detailed Web site (www.tricare.osd.mil) with numerous links to the Military Healthcare System and the DoD. The TRICARE Web site has been an invaluable resource for tracking incoming correspondence and contacts about beneficiary concerns. The C&CS staff keeps extensive records, aggregates the data, and creates monthly reports. The data below are for the first six months of calendar year 2000.

The Panel is concerned that issues related to access may be embedded in other categories and that access issues may thus be underreported.

Number of inquiries and comments received by the TRICARE C&CS Directorate from January 2000 to June 2000

Beneficiary Issues:	**Number / # Rank**	
Claims	3128	# 1
Basic Information	1236	# 2
Enrollment	763	# 3
CHCBP	499	# 4
Pharmacy	294	# 5
Eligibility	206	# 6
Healthcare for life	141	# 7
Providers	112	# 8
Pre-authorization	103	# 9
Reimbursement	98	#10
Access	67	#11
Other	969	—
Total	**7616** =	**1269 comments per month/ average**

CHAPTER VII
Strengthen the National Quality Management Program

Panel Recommendations

1. Update Department of Defense (DoD) Directive 6025.13, "Clinical Quality Management in the Military Health Services System," and include a definition of quality for TRICARE clinical healthcare and related services to orient current and future measurement initiatives.

2. Implement a uniform resourcing methodology to allow integration of resource management data and analyses into quality management processes.

3. Incorporate the National Quality Management Program (NQMP) external review of healthcare products into the audit and feedback process for improvement of healthcare and related services across the TRICARE spectrum.

4. Continue to use an external peer review agency for malpractice case reviews.

5. Support and expand interagency collaboration in forums such as the Quality Interagency Coordination Task Force (QuIC) to leverage knowledge and resources for improving healthcare quality within the federal system and across the nation.

History and Overview of the National Quality Management Program

The NQMP was established on July 20, 1995, through DoD Directive 6025.13, "Clinical Quality Management Program in the Military Health Services System." This Directive is a refinement of an earlier one, "DoD Medical Quality Assurance," from November 17, 1988. The new version revises the clinical quality assurance program to incorporate emphasis on medical readiness and managed care policies, and it establishes more databased clinical monitoring and improvement practices for healthcare services in the direct care system and in the purchased care component. It establishes guidance and standards for the Services and is the basis for their quality management programs. Its major policy areas are medical readiness, accreditation, credentials and privileges, licensure, National Practitioner Data Bank (NPDB) querying and reporting, and external review of care.

The external review of care component requires independent evaluations of specific aspects of healthcare performance by civilian organizations or consulting companies. From 1986 to 1995, external

review of care took place through the Civilian External Peer Review Program (CEPRP), which evaluated episodes of care and compared provider practices against national standards.

Although it found quality of care in the Military Health System (MHS) to compare favorably with that in the civilian sector, the early CEPRP was of limited use for quality improvement because its primary focus was to find and assess care outside of (below) professional consensus standards and to provide retrospective information to the practitioner.

In 1995, CEPRP was evolved into "Special Studies" under the NQMP. Special Studies were developed to find best clinical practice and to support improvement of care by focusing on processes and outcomes, using scientifically sound analytical methods and risk adjustment modeling to account for associated patient risk factors. Use of resources was also evaluated. Areas of care evaluated under Special Studies have included obstetrics, cardiovascular disease, asthma, clinical preventive services, and orthopedics. Significantly, the Special Studies not only provided external review of care and the ability to assess and demonstrate the quality of care in the system, but also allowed internal/external comparisons of care and support of Military Treatment Facility (MTF) accreditation.

More recently, the selection of topics and questions, study designs, and risk adjustment models for Special Studies has been performed by the Scientific Advisory Panel (SAP), which was established about two years ago with representatives from each Service and TRICARE Management Activity (TMA). The SAP meets monthly to monitor progress of studies and address related issues. Before the SAP was established, study results were used mainly at the MHS and Surgeons General level to assess care. Copies of Special Studies were also sent to facilities that participated in the studies, but at the provider level—so important to both improvement of the process and education—these excellent studies were rarely considered.

Study results are now placed on a special Web site called the Medical Data Executive Information System (MDEIS), which is open to military healthcare personnel who are involved with or have an interest in improving care in their facility, Service, or MHS. An educational program has also been put in place to communicate results of Special Studies and other external review of care work to the field (MTFs, Regions, and Surgeons General Offices [SGOs]).

One of the other methods for external review of care is the use of Health-plan Employer Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA). NCQA created HEDIS metrics to standardize performance measures across managed care organizations (MCOs) to support comparison among MCOs and to improve care. Metrics similar to HEDIS have been used since 1996 to evaluate active duty personnel and their dependents. DoD does not use exact HEDIS methodology, however, because the data are not available in automated information systems. HEDIS measurement comparisons are difficult at best. HEDIS data are available on the TMA Web site (www.tricare.osd.mil).

External review of care has also used ORYX™ performance measures, a product of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), since 1998. JCAHO requires use of selected metrics for accreditation of MHS inpatient facilities. This function was centralized under the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA])/TMA to reduce costs and standardize the performance measures available to inpatient MTFs across the MHS. Six metrics are reported to JCAHO each quarter by its independent contractor, and JCAHO uses them in connection with its triennial facility accreditation surveys.

To support the selection of ORYX measures for MTFs and address ORYX-related issues and changes, the ORYX Steering Committee (OSC) meets monthly with representatives from each Service and TMA. ORYX data are available to MTFs, Lead Agents, SGOs, and OASD(HA)/TMA through MDEIS, which was developed for display of ORYX data because of the need for statistical process control charting of the data.

For fiscal year 2001, external review of care will include use of performance measures developed by the DoD/Department of Veterans Affairs (DVA) Clinical Practice Guideline (CPG) Work Group to measure compliance with CPGs and the effect of implementing CPGs for disease management. The DoD/DVA CPG Work Group has been developing CPGs for the past two years and has issued finalized CPGs in areas such as hypertension, low back pain, asthma, and diabetes.

A final area of external review of care is the external peer review agency's review of paid malpractice cases for standard of care determinations. This process has been in place since 1998. The purpose is to provide the SGOs with an additional opinion from outside the military system as to whether the standard of care had been met (see Chapter III).

Concerns About the National Quality Management Program

Many concerns about the NQMP have been related to the external review of care component. They include lack of tri-Service participation in development of Special Studies, inadequate value added at the MTF level, absence of an educational program to communicate results with the field, and lack of external review for malpractice cases to balance the opinion of the intra-Service reviews. Efforts have been made to address these issues.

The SAP was established to select topics and questions for Special Studies. The SAP also provides input for development of scientifically sound Special Study designs and risk adjustment models, and it reviews study plans and final reports for statistical validity. The SAP meets monthly to monitor progress of studies and address related issues. Establishment of the SAP has improved the quality of the Special Studies, allowed selection of study topics with more value for each Service, and provided the Services an opportunity to work together using a common vehicle to improve care in the MHS.

Before the SAP was established, Special Study results were used mainly at the OASD(HA) and SGO level to monitor and assess the quality of care in the system. Copies of Special Studies were also sent to MTFs that participated in the studies, but these facilities were not obligated to use them for quality improvement. To promote the use of this information, improve understanding, create value added, and communicate results of Special Studies and other external review of care work to the field (MTFs, Regions, and SGOs), an educational program was established in fiscal year 2000. The educational program has three components—teleconference-based discussions of Special Studies and ORYX data with MTFs/Lead Agents/SGOs; briefings of Lead Agents and Surgeons General at annual quality conferences; and individualized consultation with MTFs about their ORYX data before JCAHO surveys. Participation by the field has been robust because of the high level of interest by healthcare personnel in the Special Studies and ORYX performance measures. To allow easier access to this information and facilitate improvement of clinical performance, Special Study results and ORYX data are placed on a secured MDEIS Web site. MDEIS is open to all military healthcare personnel who are involved or have an interest in improving care in their facility, Service, or MHS.

In 1998, for the first time, an external peer review agency was added to the malpractice case review process to review paid malpractice cases and make

standard of care determinations to augment the intra-Service reviews received by the SGOs. The addition of the external agency peer reviews has been valuable in providing an outside review to the SGOs to facilitate the final determination on each paid malpractice case. (See Chapter III for more detailed discussion.)

Panel Deliberations

The Panel was briefed on DoD Directive 6025.13, the elements of the NQMP, and the methods for external review of care used to assess and improve care. Discussion by the Panel focused on the components of the NQMP and the external review of standard of care used to assess and improve the quality of care delivered across the MHS. The Panel reviewed the information with respect to the Cox News Service articles, the related Quality Initiatives, and the current patient safety environment.

The Panel was briefed on DoD's participation in the QuIC and the patient safety effort by OASD(HA)/TMA with respect to the recent Institute of Medicine report, "To Err is Human: Building a Safer Health System." The QuIC, an interagency forum for quality issues chaired by the Director of the Department of Health and Human Services' Agency for Healthcare Research and Quality, developed a unified response to the President's Executive Directive on the development and implementation of a plan to reduce medical errors. The Panel understands that DoD is participating with other agencies on the QuIC.

The Panel was also briefed by the external peer review agency that performs the standard of care reviews for paid malpractice cases. The information on standard of care reviews is discussed and evaluated in Chapter III.

Panel Conclusions

1. The NQMP is essential for providing the framework and structure for quality management within the direct care system.

2. Establishment of tri-Service committees, such as the SAP and the OSC, and of an educational program to promote use of information from Special Studies and performance measures (HEDIS, ORYX™, CPGs) for clinical performance improvement are appropriate steps toward improving the NQMP and quality of care across the direct care system.

3. The absence of a standard methodology for resourcing (e.g., financing, staffing, patient-level cost accounting) across Services for clinical care and services inhibits quality and utilization management.

4. Addition of the external peer review agency to the malpractice case review process enhances objective review of malpractice cases. (However, initial experience has been that it increased the cost and slowed the process.)

5. Combined interagency efforts such as the DoD/VA CPG Work Group and the QuIC help to achieve common initiatives in the pursuit of healthcare quality.

Panel Recommendations

1. Update DoD Directive 6025.13, "Clinical Quality Management in the Military Health Services System," and include a definition of quality for TRICARE clinical healthcare and related services to orient current and future measurement initiatives.

2. Implement a uniform resourcing methodology to allow integration of resource management data and analyses into quality management.

3. Incorporate the National Quality Management Program (NQMP) external review of healthcare products into the audit and the audit and feedback process for improvement of healthcare and related services across the TRICARE spectrum.

4. Continue to use an external peer review agency in malpractice case reviews.

5. Support and expand interagency collaboration in forums such as the Quality Interagency Coordination Task Force (QuIC) to leverage knowledge and resources for improving healthcare quality within the federal system and across the nation.

CHAPTER VIII
Ensure That All Laboratory Work Meets Professional Standards

Panel Recommendations

1. Consolidate cytopathology centers across the Military Health System (MHS).

2. Develop supportive "production-based" (reportable test) staffing models to ensure uniform adequacy of staff levels and ongoing training across all clinical laboratory disciplines.

3. Use the Centralized Credentials Quality Assurance System (CCQAS) to enhance the management of credentials of all laboratory professionals, whether officer, enlisted, contract, or civil service.

4. Standardize competency assessments for all laboratory personnel across the direct care system.

5. Require that military personnel meet federal standards and that civil service and civilian contract personnel meet the higher of federal or local jurisdictional standards.

History and Overview

Allegations of inferiority of military laboratories' standards were made in the series of articles published by the Cox News Service in 1997. The basis of these allegations was that the Department of Defense (DoD) was exempt from the certification requirements of the Clinical Laboratory Improvement Act (CLIA) of 1967, which was primarily confined to laboratories involved in interstate commerce and did not specifically address operations within MHS laboratories. The CLIA was amended in 1988 to cover all MHS peacetime laboratory operations (which are compliant with the amended CLIA). It granted only very restricted exceptions for intrinsic operational requirements in the areas of proficiency testing and supervisory oversight of deployable (field) laboratory units. The oversight authority for CLIA is the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (DHHS).

Clinical Laboratories

The DoD developed the Clinical Laboratory Improvement Program (CLIP) to establish and provide oversight for laboratory standards in the MHS. This program is based on and duplicates (except for the limited exceptions noted above) the standards promulgated under the 1988 amendments to CLIA. Oversight of the MHS program is the responsibility of the Office of Clinical Laboratory Affairs (OCLA) in the Armed Forces Institute of Pathology (AFIP). OCLA, which was chartered under the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]), is now part of the AFIP. The program has 1,415 certificates in force covering 2,963 testing sites. Major program standard areas are Personnel Standards, Quality Control, Quality Assurance, Procedure Manuals, the Patient Test Management Process, Proficiency Testing, and Inspections and Sanctions. OCLA is staffed by nine personnel (five officers, four enlisted) representing each of the Services. More than 50 laboratory specialists representing every technical specialty served on various committees and subcommittees during development of the DoD CLIP.

Within the OCLA structure, the OASD(HA) chartered the Laboratory Joint Working Group (LJWG) in 1995. The LJWG is chaired by the AFIP Director and has 25 members, including Service consultants and representatives from each TRICARE region, the Department of Veterans Affairs, and the Public Health Service (PHS). One of the LJWG's initiatives during the past two years was an effort to consolidate cytopathology centers across the MHS, which offers significant advantages in terms of managing staffing levels, staffing competency, and staffing continuity. The plan has been approved in concept by each of the Service Surgeons General and is now undergoing refinement.

The allegation that military laboratory standards were inferior was based largely on perceived differences in requirements for military and civilian laboratories. This perception was based on the DoD's exemption from the 1967 requirement to acquire CLIA certification. The reason for this exemption was DoD's readiness and field mission to deliver medical care on ships, in remote areas, and so forth. Direct laboratory oversight by a pathologist, a CLIA requirement, would be untenable, for example, on a submarine.

CLIP was developed and designed to mirror the national standards for laboratory services established by CLIA. A memorandum of understanding between the DoD and the DHHS establishes CLIP's parity with CLIA. All fixed (nondeployable) facilities within the MHS are covered by CLIP. Although the MHS can present compelling evidence that CLIP easily meets or exceeds standards promulgated by CLIA, detractors might point out that CLIP is a program contained within the MHS to monitor the MHS—"the fox guarding the chicken coop." This concern is credibly addressed by the oversight provided by agencies outside DoD that survey, test, and provide accreditation for Military Treatment Facilities (MTFs) in the MHS.

All MTFs within the MHS are obligated by DoD Directive to be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). JCAHO has a two-year laboratory inspection cycle, and its laboratory accreditation program has "Deemed Status" for CLIA certification. "Deemed Status" conveys that meeting JCAHO laboratory standards, de facto, meets CLIA standards. All MTF laboratories must be accredited by JCAHO or a deemed equivalent agent (see below).

The College of American Pathologists (CAP) also accredits laboratories. Virtually all clinical laboratories within the MHS are CAP-certified laboratories and have held this accreditation for many years. CAP also has "Deemed Status" for CLIA certification. CAP accreditation conveys

meeting or exceeding CLIA requirements. CAP accreditation also has "Deemed Status" for JCAHO laboratory accreditation. Thus, CAP accreditation (achieved by the great majority of MTF laboratories) has "Deemed Status" for both JCAHO and CLIA certification. The Commission on Office Laboratory Accreditation (COLA) also has "Deemed Status" for CLIA certification. A small number of clinical laboratories in the MHS are COLA-accredited.

Any nonmilitary clinical laboratory that must be, or wishes to be, CLIA-certified must submit to HCFA an application and the laboratory's assurance that it meets all CLIA certification requirements. HCFA then has the option of inspecting any clinical laboratory it certifies, but given the huge number of clinical laboratories in the United States, it actually inspects only a very small portion of those it certifies. CAP, JCAHO, and COLA laboratory accreditation all require biennial inspection by on-site survey and therefore meet or exceed CLIA certification requirements. All MHS facilities, by virtue of their CAP, JCAHO, and/or COLA laboratory accreditation, meet or exceed CLIA certification requirements.

Blood Banks

The Center for Biologics Evaluation and Research (CBER) in the Food and Drug Administration (FDA) is responsible for ensuring the safety, efficacy, potency, and purity of the nation's supply of blood and blood products. FDA/CBER also inspects blood establishments and monitors reports of errors, accidents, and adverse clinical events. All Blood Donor Centers (BDCs) and Transfusion Services within the MHS are subject to these inspections, with no exceptions or waivers.

One hundred percent of random donor units produced within the direct care system are FDA-licensed. In addition, all BDCs within the MHS are voluntary members of the American Association of Blood Banks (AABB). AABB was established to promote the highest standard of care for patients and donors in all aspects of blood banking.

The Armed Services Blood Program Office (ASBPO), established in 1952, is a joint health agency charted to monitor the implementation of blood program policies established by the OASD(HA) and to coordinate the blood programs of the military Services (Army, Air Force, and Navy) and the unified commands. The Army Surgeon General, on behalf of the Secretary of the Army, serves as the Executive Agent for the ASBPO for administrative support and staff supervision. The Joint Chiefs of Staff (JCS), by memorandum of understanding, are responsible for the review and provision of guidance in all matters regarding blood support in joint operational planning. The OASD(HA) provides policy guidance to the ASBPO. All of the ASBPO elements function together to operate the military blood program successfully.

The Director of the ASBPO is a member of the FDA Blood Products Advisory Committee and the FDA Blood Availability Working Group. The Director of ASBPO is the DoD Liaison to the DHHS Blood Safety and Availability Committee, the PHS Blood Safety Teleconference, and the AABB Standards Program Committee. Service members and ASBPO deputies serve on the AABB Technical Manual Committee, the North American Technical Advisory Group Health Level 7 (HL7) Coordinating Committee, the AABB Accreditation Program Committee, the AABB Coalition for Regulatory Reform, the AABB Quality Systems Subcommittee, the Uniform Donor History Questionnaire Working Group, and the AABB FDA Liaison Working Group.

Cytopathology

For cytopathology accreditation, CAP requires that cytopathology laboratories participate in an approved cytology proficiency testing program. Cytopathology laboratories within the MHS

participate in the CAP comparison program in cervicovaginal cytopathology. The results of all cytology testing slides are graded by CAP and reported in an interlaboratory format. The cytopathology quality assurance processes, clinical correlations, statistical evaluations, and competency assessments expected by this accrediting agency were in effect within the MHS during the 1992–1995 time period referenced in a specific Cox News Service article. Each MHS laboratory's level of compliance during this period was determined by on-site inspections by CAP. Accredited laboratories were in compliance at that time and remain in compliance today.

The Cox News Service articles also raised the issue of staff workload levels for cytotechnologists in the presentation of one problematic instance. In regard to workload, the Panel was informed that HCFA first specified a limit of 100 slides per day in the *Federal Register* in February 1992. Implementation of this limit, as well as proficiency testing for cytologists and cytotechnologists, spanned the period of 1992 to 1995 (see the Annex for a detailed chronology of DoD's implementation of CLIA regulations). In February 1995, DHHS officially approved the College of American Pathologists as an organization that may accredit laboratories for purposes of establishing their compliance with CLIA requirements. Later that year, CAP officially published the 100 slides per day limit in its inspection checklist. Therefore, the period cited in the pertinent Cox News Service article is the same period (1992–1995) in which the daily slide limit was being officially established. During this period, there were excessive workload requirements.

Today, each individual evaluating cytology preparations is limited to no more than 100 slides (one patient per slide, gynecologic or nongynecologic or both) at all sites in a 24-hour period. Individual cytotechnologists employed by the MHS are required to report the number of slides (if any) screened in a laboratory outside the MHS, along with the number of hours worked in accordance with current off-duty civilian employment policies. This limit represents an absolute maximum number of slides and is not used as a performance target for individuals.

All gynecologic smears interpreted as showing reactive or reparative changes, atypical squamous or glandular cells of undetermined significance, or premalignant (dysplasia, cervical intraepithelial neoplasia, or all squamous intraepithelial lesions including human papilloma virus-associated changes) or malignant findings are confirmed by a pathologist. In addition, at least 10 percent of all slides from gynecologic cases interpreted as negative for reactive, reparative, atypical, premalignant, or malignant cells are selected at random from the total caseload and from patients or groups of patients that are identified as having a high probability of developing cervical cancer, based on patient information. A technical or general supervisor in cytology reviews the selected negative slides before the diagnosis is released to the submitting provider. MHS cytology laboratories compare clinical information with cytology reports and compare malignant and premalignant gynecology reports with the histopathology report.

MHS cytology laboratories establish and document annual statistical evaluations of the number of cytology cases examined, the number of specimens processed by specimen type, the volume of patient cases reported by diagnosis (including the number reported as unsatisfactory for diagnostic interpretation), the number of gynecologic cases for which cytology and available histology are discrepant, the number of gynecologic cases where any rescreen of a normal or negative specimen results in the reclassification as malignant or premalignant, and the number of gynecologic cases for which histology results were unavailable to compare with malignant or premalignant cytology cases. Each laboratory evaluates the case reviews of each individual examining slides against the laboratory's overall statistical values and

documents corrective actions and any discrepancies, including reasons for the deviation.

Panel Deliberations

The Panel considered specific references in the Cox News Service articles that conveyed material about clinical laboratories and cytopathology. It was briefed on and reviewed specific reference material on policy and policy implementation pertinent to the staffing, operation, training, oversight, and accountability related to the services categorized above within the DoD/MHS—field settings and fixed, nondeployable facilities. It reviewed specific examples and discussed patterns of proficiency testing results. In addition, the Panel, and later a subcommittee of the Panel, met with the laboratory consultants and key staff from the Surgeon General's Office (SGO) to explore and clarify two specific areas of services—one cited in the Cox News Service articles (cytopathology) and one (blood banking) needed to fulfill the comprehensive assessment directed through the Panel's charter.

Through the process above, the Panel understands that, in selected cases, pertinent regulations and standards were in early implementation before the time frame of the articles, and this factor might explain, in part, some misperception. Further, the Panel believes that, commendably, laboratory regulations and standards are frequently reviewed and remain dynamic—consistent with changes in technology and other environmental factors.

Panel Conclusions

1. The allegation that military clinical laboratories, based on their exemption from CLIA requirements, meet a lesser standard than civilian ones is misleading, as is any derived implication that military laboratory services were, or are, therefore inferior when compared with analogous civilian ones.
2. MHS MTFs provide services with oversight requirements that are at least as stringent as those in civilian sector clinical laboratories.
3. Efforts to integrate clinical workload, resource allocation, and staffing to support stability of operations and training with a comparable (uniform) tri-Service methodology are commendable, but they need to be more comprehensive, more vigorously implemented, and fully resourced.
4. Management of credentials for laboratory professionals, especially in situations where licensing or certification are not state or federal requirements, could be improved.

Panel Recommendations

1. Consolidate cytopathology centers across the Military Health System (MHS).
2. Develop supportive "production-based" (reportable test) staffing models to ensure uniform adequacy of staff levels and ongoing training across all clinical laboratory disciplines.
3. Use the Centralized Credentials Quality Assurance System (CCQAS) to enhance the management of credentials of all laboratory professionals, whether officer, enlisted, contract, or civil service.
4. Standardize competency assessments for all laboratory personnel across the direct care system.
5. Require that military personnel meet federal standards and that civil service and civilian contract personnel meet the higher of federal or local jurisdictional standards.

CHAPTER IX
Ensure the Accuracy of Patient Data and Information

Panel Recommendations

1. Move forward rapidly with development and implementation of the Composite Health Care System, Second Implementation (CHCS II) to provide more comprehensive, efficient electronic medical record support for all Department of Defense (DoD) beneficiaries.

2. Continue as planned to enhance the Composite Health Care System, First Implementation (CHCS I) and ultimately absorb it into CHCS II through phased implementation of CHCS II.

3. Ensure that appropriate analytical and ad hoc reporting capabilities are available for CHCS II data to provide pertinent assessment information for management at all levels within and across the military Services and for all healthcare settings of the military.

4. Ensure that a longitudinal electronic health record exists for active duty military personnel, maintained through a global capability to link pertinent information databases available for peacetime and deployed operations.

5. Participate actively in national and federal interagency activities to develop policy and data standards with organizations such as the National Committee on Vital and Health Statistics (NCVHS).

6. Plan, program, budget, and fully fund business process reengineering resource requirements to facilitate full implementation of the MHS Optimization Plan and Force Health Protection.

7. Establish strategic goals to progressively enhance "connectivity" with Computerized Patient Records (CPRs) generated by managed care network providers and other providers not in the direct care system. When feasible, such integration must support common (uniform) data quality standards, data aggregation, audit, and robust capabilities for analysis of data and generation of reports.

Introduction

The Cox News Service articles cited specific examples of egregious clinical outcomes, associated on occasion with deficiencies in medical records that were considered to be causal or contributory factors. Generally speaking, these inadequacies could be further identified as a lack of one or more of the following: accuracy, completeness, timeliness, and continuity.

It remains true that the delivery of efficient, effective healthcare is dependent upon accurate, timely, and comprehensive clinical data and information at the point of care. The support of medical practice in peacetime and in wartime within the context of the complex, widely dispersed managed care system presented by the MHS poses many challenges. Patient data and information that are currently stored in paper records must, over time, be made accessible to all TRICARE providers in a single, standardized, comprehensive electronic health record. Further, this electronic health record must allow appropriate privacy and confidentiality of patient data, and it must be protected from loss and unauthorized disclosure.

The comprehensive electronic capture, analysis, and use of DoD beneficiary health data has been impeded by the inability of current systems to perform coordinated electronic appointment scheduling, clinical documentation, consultation management, results reporting, and coding. This is a major challenge, considering that there are an average of 250,000 hospitalizations and 50 million outpatient visits or encounters per year across the direct care system. Although the DoD has undertaken important initiatives to improve medical records, the bulk of this information is still being recorded in paper records. Some data capture is occurring within site-specific ("stove-piped") or Service-specific electronic systems.

The history, physical examination findings, and diagnostic conclusions from patient encounters are recorded manually in paper medical records. However, most patient data from laboratory, pharmacy, and radiology care are captured and integrated in catchment-area electronic databases of CHCS I.

Within the DoD, there is growing recognition of the need for increasing sophistication of analytical capabilities applicable to health services. Such capabilities are dependent on improved infrastructure, uniform data management across military Services, and appropriate refinement of policy and technological support. At the time of this review, the Panel was advised that current approaches, funded in the fiscal years 2002–2007 program objective memorandum (POM), specifically address known needs.

Panel Deliberations

The Panel was briefed on the history of clinical information systems in the direct care system and various initiatives undertaken by, or under way through, the direct care system to improve the accuracy of patient data. A summary is presented below.

Composite Health Care System, First Implementation

Before CHCS I (c. 1990), DoD clinical information technology projects were piecemeal and site- and service-unique. Military treatment facilities (MTFs) used different hardware and software. Numerous stand-alone systems were the rule. There was little interoperability and no enterprisewide approach to medical information management. Paper records were the only approved option for documenting care.

CHCS I, an early, major automation initiative—part local campus network and part database—tracks appointments, facilitates patient administration, records laboratory and radiology results, manages prescriptions, and performs other

important administrative tasks for all MTFs within a catchment area. Using keyboard commands, a healthcare provider can access patient information as recorded in CHCS I for that catchment area. CHCS I has somewhat improved provider access to patient data by providing online healthcare information related to allergies, prescriptions, and recent clinic visits and hospital admissions. Total use capacity designed into the MHS information management/information technology infrastructure, however, has proven inadequate.

This type of catchment area architecture, supported with files and tables unique to each catchment area, was not designed to facilitate the regional, real-time exchange of information from one CHCS host system to another among catchment areas. The CHCS I architecture cannot provide an integrated, global solution for a single worldwide electronic medical record for each beneficiary.

Recent releases of CHCS I, however, have started to address the limitations of the catchment area architecture by enabling healthcare providers to send automated requests for patient records to another CHCS I host.

CHCS I has been successfully deployed worldwide to more than 100 MTFs and more than 600 associated clinics. Software upgrades have been implemented worldwide every six months.

Composite Health Care System, Second Implementation

The military computerized patient record (CPR), through CHCS II, will add significant key functions to the current direct care systems. These additional functions were identified as high priorities for the MHS Optimization Plan and Force Health Protection. Initially, however, established functions within CHCS I, the largest of the systems currently fielded by the MHS, will be accessed through the user interface of CHCS II. Over time, to reduce the costs of sustaining this legacy environment, future releases of CHCS II will replace CHCS I functions, allowing CHCS I to be fully replaced by CHCS II by fiscal year 2008.

The MHS Optimization Plan has expanded the focus of military medicine from providing primarily interventional services to enhancing wellness and health promotion activities. The basic assumption behind this strategy is that improving the health of the entire population will reduce demand for more costly tertiary treatment interventions in some circumstances. CHCS II will provide the information foundation to identify risk factors and to facilitate the delivery of health promotion services. CHCS II will use and promote standard terminology, reduce inappropriate variations in clinical practice, support the use of clinical practice guidelines, and create a central data repository of well-defined clinical data sets. Through direct provider use of the system, CHCS II will assist providers in capturing more complete, relevant information from patients, leading to increased data accuracy, more appropriate care, and a predictable attendant reduction in medical errors.

As a key element, the system will support the systematic measurement and recording of a patient's health status and functional level to achieve more precise assessments of the outcomes of patient care. The logical basis for all diagnoses and conclusions is captured as a means of documenting the clinical rationale for decisions about the treatment of the patient. This ensures that the patient's symptoms, the provider's diagnoses, the prescribed treatment, and the outcome of care are linked in the record. Linkage of the clinical records of a patient from various settings and time periods will create a longitudinal record of events related to that patient's health.

CHCS II will also provide support for the process of clinical problem solving. The system will be linked to established clinical knowledge bases, and it will make information from selected peer-reviewed journals and other reliable sources of

information more readily available to providers. Built-in alerts and reminders inform providers of potential conflicting orders, clinical values outside the normal range, or a patient's need for specific preventive care services. (See also the Clinical Decision Support Tools Demonstration section below.)

CHCS II will address data integrity and confidentiality by ensuring that the CPR is accessible only to authorized users. Role-based access control and other security measures will prevent loss of or unauthorized access to personal information and safeguard against the inappropriate modification of data. Authorized users involved in direct patient care will have access to CHCS II 24 hours a day, seven days a week. This level of record availability will make it possible for any authorized provider to access current information about an individual whenever necessary.

In supporting concurrent access to the CPR from multiple authorized providers, the system can create opportunities for better coordination of care. For example, a provider may perform a telephone consultation with a specialist during which both providers can view the patient's record simultaneously. The system will also allow some analysis of the "business practices" (resource impacts) of several discrete members of a healthcare team caring for a patient during a single visit—providing greater assurance, for example, that testing is not redundant over the course of a coordinated patient care encounter.

CHCS II will integrate some broadly recognized, leading commercial products. It will achieve structured data collection by organizing data collected from a note-writing tool and other sources according to a vocabulary defined in a standard lexicon. Using such model-based terminology, data sets, and structure will ensure that uniform, comprehensive data are collected and maintained for all beneficiaries. Perhaps most important, such data can become available for system analysis and management as well as process improvement.

These planned functions of CHCS II offer substantial promise in resolving the medical record concerns identified in the Cox News Service articles. In addition, there is growing recognition in the medical community that a significant number of medical errors may occur because of illegible or otherwise defective records. Early experience with CHCS I has suggested that error risk can be reduced through electronic documentation of health data, automation of the order entry process, direct data entry by the provider, and lesser dependency on transcription processes through "reuse" of existing patient data from other areas of the record to populate an encounter note.

Implementation of CHCS II

CHCS II will be implemented in multiple releases by TRICARE region. CHCS II, Release 1, is scheduled for implementation in the third quarter of fiscal year 2001. Future releases are planned at six-month intervals.

The first CHCS II release will address the outpatient setting. Initial functionality provided includes patient health history, role-based security, encounter coding, alerts and reminders, results reporting, immunization tracking, health risk assessment, patient self-assessment, clinical and dental readiness documentation, preventive healthcare services, and outpatient and diagnostic procedure coding.

DEERS and the National Enrollment Database (NED)

The current interface between CHCS I and the Defense Enrollment Eligibility Reporting System (DEERS) provides CHCS I with access to eligibility and enrollment-related information, and also provides a bidirectional interface with DEERS in support of TRICARE enrollments generated

from CHCS I. Through the National Enrollment Database (NED), CHCS I will no longer be used to perform TRICARE enrollments. Rather, CHCS I (and later CHCS II) will receive enrollment data from NED. TRICARE Prime enrollments for all categories of beneficiaries will be performed by Managed Care Support Contractors (MCSCs) using a refined DEERS desktop enrollment software application provided by the Defense Manpower Data Center (DMDC). This refined software is currently being prepared and requires significant purging of duplicate entries and other error corrections.

Primary Care Managers (PCMs) by Name

In both the military and civilian healthcare settings, designating a specific PCM has proven to enhance patient satisfaction, the provision of preventive services, and the coordination of healthcare. A PCM is a physician (typically a family practitioner, internist, pediatrician, or general practitioner) or other privileged healthcare professional who serves as the patient's first direct medical contact with the plan's healthcare system. PCMs also refer patients to specialists if needed. PCMs provide follow-up care for patients after they have received care from a specialist. The PCM is the coordinator of care, as intended by the Office of the Assistant Secretary of Defense (Health Affairs (OASD[HA]).

The Panel wishes to emphasize that deployments of medical personnel and other training and military-unique requirements might interrupt the desired and intended purpose of enrollment to a PCM. For this reason, military providers can rarely have a "stand-alone practice." In the military direct care system, the PCM concept will typically be implemented by small teams of healthcare providers, rather than by individuals, to ensure continuity and accountability of patient care in the event of deployments or other commitments.

Clinical Decision Support Tools Demonstration

Because the deployment of CHCS II will offer a platform for coalescing other healthcare technologies, the Panel approved a recommendation from the TRICARE Management Activity (TMA) in September 1999 to provide $3 million in funding for a project to demonstrate and assess an off-the-shelf clinical decision support tool called Problem Knowledge Couplers (PKCs). The Panel understands that this project intends to assess the impact of PKCs on optimization of resources, improvement of quality of care, improvement of patient information collection, documentation, and involvement of patients with their own healthcare treatment, health maintenance, and disease prevention.

PKCs constitute automated clinical decision support tools that are built from evidence-based treatment modalities and published research, and that are linked to three major applications basic to clinical care—screening, diagnosis, and care management.

A demonstration project at eight diverse MTFs throughout the United States has been initiated in the direct care environment to:

- Determine that clinical couplers can successfully and efficiently identify patient problems and risk factors,
- Evaluate business workflow processes and identify considerations for implementation of the CPR and decision support tools, and
- Assess the acceptance of such software tools in the clinic setting by patient and healthcare team users.

The coupler tools are capable of gathering much-needed information about the patient (history and screening functions) in advance of the actual physical examination. In association, the CHCS II

system has been designed to allow the coupler software to populate the patient's history, physical, and other forms that become a part of the patient's permanent computerized record. The ability to gather, evaluate, and store this information may create a powerful capability for the MHS to produce a clearer picture of the health status of its beneficiaries as consistent care management plans are followed.

This demonstration project will continue until December 2001, when a final report will assess, among other aspects, the responses from clinician and patient users alike. At that time, it will be determined whether the PKC tool has merit for use within the MHS.

Other Assessments of the Panel

Institute of Medicine Report. The Institute of Medicine (IOM) in its recent report, "To Err is Human: Building a Safer Health System," estimated that medical errors cause between 44,000 and 98,000 deaths per year in the United States. The report stated that "automated information and decision support systems are effective in reducing many types of errors." Implementation of CHCS II is an integral part of the DoD strategy for reducing the potential for medical errors. As summarized above, the military CPR will address several key findings set forth in the IOM report.

Pharmacy Data Transaction Service. The Pharmacy Data Transaction Service (PDTS) automation system will capture data for prescriptions filled at all locations throughout the MHS, including the direct care system, the MCSC Retail Pharmacy Network, and the National Mail Order Pharmacy. PDTS will enable interactive clinical screening of a complete patient profile for drug interactions, therapeutic overlaps, and duplicate therapies, regardless of where the other prescriptions were filled. PDTS will assist in tracking refills, monitoring compliance, and searching for overuse and underuse of medications. When filling prescriptions, the pharmacy will monitor patient history for alerts on early and late refills, incorrect duration of therapy, drug/age precautions, and inappropriate dosing. PDTS will also provide a robust data repository for detailed and aggregate management and clinical reporting. This important data management capability is functionally linked to CHCS I and will be subsumed by CHCS II.

NCVHS Report on Uniform Data Standards for Patient Medical Record Information. In August 2000 the National Committee on Vital and Health Statistics (NCVHS) presented the "Report on Uniform Data Standards for Patient Medical Record Information" to the Department of Health and Human Services (DHHS), as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The report stated that work on data standards is moving too slowly and recommended that DHHS review standards forwarded by NCVHS within the next 18 months and decide whether to adopt them in the form of a proposed rule, with solicitation of public comment and subsequent issuance of a final rule. It was noted that this process could take up to five years. NCVHS recommended that the federal government:

- Participate in and provide funding to accelerate development of testing and early adoption of standards now being developed,

- Enact national privacy and confidentiality legislation and other laws to encourage the use and exchange of electronic information, and

- Accelerate development and implementation of a healthcare information infrastructure to include standards, laws, business practices, and technologies facilitating the electronic exchange of healthcare data, interoperability between computer systems, comparability of data, and better quality, accountability, and integrity of data.

The Panel understands that the OASD(HA) has participated in various interagency and other forums to assist the development and implementation of electronic record and other related data standards.

Concerns of the Panel

System Change

Implementation of a CPR can provide a powerful tool in support of organizational improvement. Required business process reengineering seems to be under early development in the MHS. Healthcare providers are developing new skills and documentation methodologies. Education, training, leadership support, business process reengineering, and policy refinement will be necessary prerequisites for the successful implementation of CHCS II and the realization of the overall goals of the MHS Optimization Plan and Force Health Protection Program. The Panel was not briefed on the resource requirements to meet these needs and does not know whether these requirements have been adequately identified and planned.

Additional Issues

The Panel believes that this chapter adequately addresses the requirements of its charter to review DoD initiatives to "improve the accuracy of patient data and information." It is recognized that there are other important CPR initiatives under way in the United States, including initiatives in the Department of Veterans' Affairs (DVA). The Panel understands that OASD(HA) plans to maintain an important participatory role in some of these efforts because there are significant unresolved national issues (e.g., confidentiality legislation) and significant system challenges (size, mobility, complexity, field deployments, etc.) for which the experience and projected applications of DoD must be broadly considered.

The Panel was unable, in the time available, to explore more fully some concerns related to the successful implementation and completion of initiatives cited this chapter. In addition to the system change described above, these concerns include:

- Consistency with which automation initiatives are associated with pertinent policy development—for example, the format of CPR content, transcription (preparation) of medical record summaries, data quality requirements, and data standards specifications for TRICARE contractors;

- Creation of analytical and ad hoc report generating capabilities in the early development and implementation of CHCS II;

- Development of the Theater Medical Information Program and the functional integration of it with CHCS II;

- Planning and capabilities designed to align CHCS II with other needed automation infrastructure or programs such as resource management, disability processing, and DVA analogues; and

- Increased capability for communication of patient clinical information between direct care and purchased care providers.

Panel Conclusions

1. Medical record deficiencies increase the risk of errors and undesired outcomes. These factors were appropriately criticized in the Cox News Service articles.

2. The direct care system is on schedule to acquire and implement a useful, systemwide, electronic patient record that, when fully implemented, will improve accuracy, completeness, timely availability, and continuity over time.

3. In a time of massive change in the environment of healthcare, the MHS is challenged to actively participate in associated policy and standards development in various forums relating to further development and implementation of an electronic medical record.

4. Directive policy is required to reengineer business processes within the MHS to facilitate integrated analysis and benefits potentially available from use of electronic records (e.g., resource acquisition and justification, utilization, clinical encounters, outcomes, and health status).

5. Use of electronic medical records supporting "connectivity" and appropriate data and clinical information sharing and analysis is not occurring with MCSCs.

Panel Recommendations

1. Move forward rapidly with development and implementation of the Composite Health Care System, Second Implementation (CHCS II) to provide more comprehensive, efficient electronic medical record support for all Department of Defense (DoD) beneficiaries.

2. Continue as planned to enhance the Composite Health Care System, First Implementation (CHCS I) and ultimately absorb it into CHCS II through phased implementation of CHCS II.

3. Ensure that appropriate analytical and ad hoc reporting capabilities are available for CHCS II data to provide pertinent assessment information for management at all levels within and across the military Services and for all healthcare settings of the military.

4. Ensure that a longitudinal electronic health record exists for active duty military personnel, maintained through a global capability to link pertinent information databases available for peacetime and theater operations.

5. Participate actively in national and federal interagency activities to develop policy and data standards with organizations such as the National Committee on Vital and Health Statistics (NCVHS).

6. Plan, program, budget, and fully fund business process reengineering resource requirements to facilitate full implementation of the MHS Optimization Plan and Force Health Protection.

7. Establish strategic goals to progressively enhance "connectivity" with Computerized Patient Records (CPRs) generated by managed care network providers and other providers not in the direct care system. When feasible, such integration must support common (uniform) data quality standards, data aggregation, audit, and robust capabilities for analysis of data and generation of reports.

ANNEXES

ANNEX A
Charter
DoD Healthcare Quality Initiatives Review Panel

Official Designation: The Committee will be officially designated the Department of Defense (DoD) Healthcare Quality Initiatives Review Panel (referred to hereinafter as the Panel).

Objective and Scope of Activity: The Panel shall review the DoD Access and Quality Improvement Initiative announced in early 1998 (together with other related quality improvement actions) to assess whether all reasonable measures have been taken to ensure that the Military Health System delivers healthcare services in accordance with consistently high professional standards. The Panel shall specifically assess actions of the DoD to accomplish the following objectives of that initiative and related management actions:

1. Upgrade professional education and training requirements for military physicians and other healthcare providers.

2. Establish "Centers of Excellence" for complicated surgical procedures.

3. Make timely and complete reports to the National Practitioner Data Bank and eliminate associated reporting backlogs.

4. Assure that Military Health System providers are properly licensed and have appropriate credentials.

5. Reestablish the Quality Management Report to aid in early identification of compliance problems.

6. Improve communications with beneficiaries to provide comprehensive and objective information on the quality of care being provided.

7. Strengthen the National Quality Management Program.

8. Ensure that all laboratory work meets professional standards.

9. Ensure the accuracy of patient data and information.

Panel Membership: The Panel shall be composed of nine members appointed by the Secretary of Defense. At least five of the members shall be persons who are highly qualified in the medical arts, have experience in setting healthcare standards, and possess a demonstrated understanding of the military healthcare system and its unique mission requirements. The remaining members shall be persons who are current beneficiaries of the Military Health System. The Secretary shall designate one member to serve as chairperson of the panel.

Panel Financing: Funding will be available through fiscal year 1999 for administrative costs of this Panel and for the express purpose of initiating or accelerating any activity identified by the Panel that will improve the quality of healthcare provided by the Military Health System.

Period of Time Required: The Panel shall exist for no longer than one year from the date of the Charter, unless renewed by the Secretary of Defense or Congress.

Official or Sponsoring Proponent to Whom the Committee Reports: The Panel shall report and submit its advice and recommendations to the Secretary of Defense.

Supporting Agency: The TRICARE Management Activity will provide a contractor for administrative and related support of the Panel.

Duties and Responsibilities: Not later than six months after the date on which the Panel is established, the Panel shall submit to the Secretary a report setting forth its findings and conclusions, and reasons therefore, and recommendations it deems appropriate. The Secretary shall forward the report of the Panel to Congress not later than 15 days after the date on which the Secretary receives it, together with the Secretary's comments on the report.

Estimated Annual Operating Costs and Man-Years: The operating costs associated with supporting the Panel's functions are estimated to be $350,000 per year, including all direct and indirect expenses. It is estimated that 3.0 FTE's will be required to support the Panel.

Number of Meetings: It is anticipated the Panel will meet at least six times per year.

Termination Date: No longer than one year from the date of the Charter, unless renewed by the Secretary of Defense or Congress.

Date Charter is Filed: (To be completed by DoD Committee Management Officer)

ANNEX B
Federal Advisory Committee Act
Selected Statutes, Regulations, and Policy Documents

Federal Advisory Committee Act

(Public Law 92-463, effective January 5, 1973.) Requires the establishment of a Committee Management Secretariat to provide government-wide oversight of advisory committees. In addition, the Act establishes a framework covering the creation, management, operation, and termination of all advisory committees reporting to the Executive Branch.

Government in the Sunshine Act

(Public Law 94-409, effective March 12, 1977.) Section 5(c) amended Section 10(d) of the Federal Advisory Committee Act. Serves as basis for closing all or part of an advisory committee meeting.

Unfunded Mandates Reform Act

(Public Law 104-4, effective March 22, 1995.) Section 204(b) provided for an exclusion from the Federal Advisory Committee Act for interactions between federal officials and their state, local, or tribal counterparts while acting in their official capacities involving shared intergovernmental responsibilities or administration.

Federal Advisory Committee Act Amendments of 1997

(Public Law 105-153, effective December 17, 1997.) Amends the Federal Advisory Committee Act to clarify public disclosure requirements applicable to the National Academy of Sciences and the National Academy of Public Administration, and excludes from the Act any committee created by these organizations. Also expands the exclusions from the definition of advisory committee to include permanent part-time officers or employees of the federal government.

Executive Order 12838

(Effective February 10, 1993.) Directs the heads of all departments and agencies to reduce the number of advisory committees "not required by statute" by one-third. Requires that the establishment of all new discretionary advisory committees be approved by the Director of the Office of Management and Budget consistent with identified needs relating to national security, health or safety, or similar national interests.

Vice Presidential Memorandum, dated June 28, 1994

Expands the president's policy of controlling the number of federal advisory committees by requiring departments and agencies to (a) work

with Congress to eliminate unneeded committees mandated by statute; (b) generally not support proposals to create new committees through legislation; and (c) reduce committee costs by at least 5 percent.

OMB Circular A-135, dated October 5, 1994

Provides guidance and instructions on the management of federal advisory committees and requires Executive Departments and agencies to establish a committee planning and review process. Information submitted to the Office of Management and Budget and the General Services Administration serves as the basis for approving the establishment of new discretionary advisory committees under Executive Order 12838.

GSA Federal Property Management Regulation—Final Rule

41 CFR Part 101-6, Federal Advisory Committee Management. Provides guidance regarding the implementation of the Federal Advisory Committee Act.

Federal Advisory Committee Act Management

"FACA was intended to authorize the establishment of a system governing the creation and operation of advisory committees in the Executive Branch of the Federal Government."

Agencies must establish uniform administrative guidelines and management controls that are consistent with the Act and the GSA Rule.

Agencies must maintain systematic information on the nature, functions, and operations of their advisory committees.

Agency heads must designate Committee Management Officers who are responsible for exercising controls and supervision over the committee management program.

Committees must be chartered before they can meet or conduct any business.

Charters must be renewed every two years or they will be terminated under the Sunset Provisions of Sec. 14. of the Act, unless otherwise provided by law.

Advisory committee memberships are to be fairly balanced in terms of the point of view represented and the functions to be performed.

Advisory committee meetings are required to be open to the public, with limited exceptions. Meeting notices and agendas must be published in the *Federal Register* to accommodate public participation.

Designated Federal Officials must approve all meetings and agendas, and attend meetings.

Detailed minutes will be kept and must contain the following:

- Date and location of the meeting,
- A record of the persons present,
- A complete and accurate description of matters,
- Discussions and conclusions reached, and
- Any advice or recommendations provided by the committee.

All advisory committee documents must be available for public inspection and copying until the committee ceases to exist.

ANNEX C
Panel Member Biographies

C. Ross Anthony, Ph.D.

Dr. Anthony is a Senior Economist at RAND and Director of the Center for Military Health Policy Research. To date, the Center has conducted research related to Gulf War illnesses, evaluations of demonstrations to test alternative ways of delivering benefits to TRICARE beneficiaries, clinical practice guideline implementation, and cost and organization of military medicine.

Dr. Anthony previously served as Vice-President and Director of the International Health Services Group of the consulting group IPAC; Director of the Office of Development Resources for Europe at the United States Agency for International Development (USAID); Associate Administrator for Program Development of the Health Care Financing Administration (HCFA), where he oversaw the development of program policy, regulations, and health services research; and as budget analyst at the Office of Management and Budget while a Robert Wood Johnson fellow.

Dr. Anthony holds a Ph.D. in economics from the University of Pennsylvania and is a former assistant professor in Economics at the University of Oregon.

Ann Brazil, R.N., B.S.N., M.H.A., C.P.H.Q.

Ms. Ann Brazil retired as a Lieutenant Colonel in the Army Nurse Corps in 1998. She currently works as Utilization/Outcomes Manager for Care Network, Inc., a Nevada-based managed care organization.

Ms. Brazil has held a variety of key nursing and management positions during her Army career including Utilization Management Staff officer, U.S. Army MEDCOM; consultant to the Surgeon General in Nursing Quality Management, Nurse Administrator, Quality Management Division, U.S. Army MEDCOM; Consultant in Nursing Quality Management to the 7th MEDCOM Commanding General; and Assistant Inspector General, Headquarters 7th MEDCOM, Europe.

Ms. Brazil's education includes the U.S. Army Baylor Program in Healthcare Administration, M.H.A., 1987; Oregon Health Sciences University, B.S.N., 1965; and the JCAHO Surveyor Course in 1994. She is certified as a Professional in Healthcare Quality by the National Association for Healthcare Quality, an organization she has served at the local, state, and national level for over 20 years.

George Joseph Brown, M.D.

Dr. Brown is the current Vice President for Acute Care Services and Facilities, MultiCare Health System, a position he assumed following his retirement from the U.S. Army. He is a retired Brigadier General in the Regular Army, with 26 years of active service.

Dr. Brown's command assignments include service as Commander, U.S. Army Hospital, Berlin, Germany; Commander, Letterman Army Institute of Research, San Francisco, California; Commander, Blanchfield Army Community Hospital, Fort Campbell, Kentucky; Deputy Commander for Clinical Services, Walter Reed Army Medical Center, Washington, D.C.; Commander, Walter Reed Health Care System at Walter Reed Army Medical Center, Washington, D.C.; Commanding General, Madigan Army Medical Center, Lead Agent Region 11; and Commander, U.S. Army Western Regional Medical Command, Fort Lewis, Washington.

Dr. Brown's education includes a B.A. in biology from Hampton Institute and an M.D. from Boston University. He entered active duty in the United States Army in 1972 and completed his internship and residency training in internal medicine at Fitzsimons Army Medical Center and a gastroenterology fellowship at Walter Reed Army Medical Center. Dr. Brown is certified by the National Board of Medical Examiners, the American Board of Internal Medicine and Gastroenterology, and the American Board of Medical Management. He is a member of the American College of Physician Executives, American College of Physicians, and the American Gastroenterological Association.

Alfred S. Buck, M.D., FACS

Alfred S. Buck, M.D., FACS, completed five years of service with the Joint Commission on Accreditation of Healthcare Organizations in April 2000 as Executive Vice-President for Standards, Performance Measures and Research.

Prior to this, Dr. Buck served a full career as an Army surgeon. He was an appointed member of the Joint Commission Task Force on Quality Improvement, while serving as the Director, Quality Assurance Division and Office of the Assistant Secretary of Defense (Health Affairs). He has served as an international consultant and representative to a number of agencies and organizations and is a member of various professional societies, including the American Medical Association, the American College of Surgeons (ACS), and the American Urological Association. He is a Clinical Professor of Surgery at the Uniformed Services University of Health Sciences, Bethesda, Maryland. Other current appointments include Vice Chairmanship of the ASTM E31 Medical Informatics Committee and consultant to the Governor's Committee on Ambulatory Surgical Care (ACS).

Honors have included the Federal Service Award (Federal Executive Association); Defense Superior Service Medal (DoD); National Performance Review Recognition (Vice President Gore's "Hammer Award"); and Honorary Life Membership in the American Society of Healthcare Engineering.

Dr. Buck holds an M.D. from Cornell University and a B.A. cum laude from Haverford College, Haverford, Pennsylvania.

Sandy J. Johnson

Ms. Sandy Johnson is the Administrative Assistant for the Legislative Section of the National Association for Uniformed Services (NAUS), as well as NAUS PAC liaison, registered lobbyist, and contributing author for the Association's magazine, the *Uniformed Services Journal.* Ms. Johnson has held this position since January 1998.

Prior to coming to NAUS, Ms. Johnson served in a variety of supervisory positions within the administrative field of the United States Army, leaving after 11 years as a staff sergeant (E-6). Ms. Johnson's military awards include the Army Commendation Medal (3rd oak leaf cluster), the Army Achievement Medal 6th oak leaf cluster, and the Army Good Conduct Award (3rd oak leaf cluster).

Ms. Johnson is currently attending Ball State University. She has also attended the Primary Leadership Course and the Basic Non-Commissioned Officers' course.

Michael W. Lord

Mr. Michael W. Lord is the Executive Director of the Commissioned Officers Association of the U.S. Public Health Service. Mr. Lord has held this position since his retirement from the Navy in July 1995.

Mr. Lord's final Navy assignment involved duties as Congressional Liaison Officer in the Navy's Office of Legislative Affairs in July 1992, where he specialized in personnel, healthcare, and naval reserve issues. He was selected for promotion to the grade of Captain in February 1995, shortly before his retirement.

Mr. Lord's education includes a J.D. from the University of Virginia, 1978; the Navy's Law Education Program; and the Navy's Basic Lawyer Course at the Naval Justice School, graduating with honors in October 1981. Mr. Lord was commissioned an Ensign in the United States Navy following graduation from the Naval Academy in 1975, where he earned a Bachelor of Science degree in Political Science. Mr. Lord is admitted to the Bar of the State of Virginia.

John Molino

Mr. John Molino is the Director of Government Affairs for the Association of the United States Army (AUSA). He has held this position since February 1997.

Mr. Molino served as a Legislative Assistant to Senator Dan Coats of Indiana and as the Assistant Director of Government and Public Affairs at AUSA. This came at the conclusion of an active duty Army career where his assignments included duty on the staffs of the Secretary of the Army, the Secretary of Defense, and the Chairman of the Joint Chiefs of Staff.

Mr. Molino's education includes an M.A. in Human Relations, Webster University, St. Louis, Missouri; and a B.A. in History, Saint Peter's College, Jersey City, New Jersey.

Joyce Wessel Raezer

Ms. Joyce Wessel Raezer is the Associate Director of Government Relations for the National Military Family Association (NFMA). She joined the association in 1995, starting as a volunteer in the Government Relations Department. As a volunteer, she served as the department's Education Specialist. She was hired as the Senior Issues Specialist in 1998, promoted to Deputy Associate Director in 1999, and to Associate Director in 2000.

Joyce was the 1997 recipient of NMFA's Margaret Vinson Halgren Award for her advocacy on behalf of military families and the Association. She received the "Champion for Children" award from the Military Impacted Schools Association in 1998. She serves as co-chair of The Military Coalition's Personnel, Compensation, and Commissaries Committee and is a national board member of the Military Child Education Coalition.

Ms. Raezer's education includes an M.A. in History from the University of Virginia and a B.A. in History from Gettysburg College, Gettysburg, Pennsylvania.

Pedro N. Rivera, M.D.

Dr. Rivera is the President and Managing Director for Government Services for the Problem Knowledge Couplers (PKC) Corporation. Dr. Rivera has been in this position since his retirement from the Air Force in 1997 as a Brigadier General

Dr. Rivera served as Director of the Department of Defense Integrated Healthcare Network, servicing over 605,000 beneficiaries and managing a five-year civilian contract of $3.7 billion. He served as CEO of two USAF Medical Centers and a Regional Hospital, Chairman for a DoD region board of directors, and co-chairman of the executive board of another DoD region.

Dr. Rivera is a Member of the American College of Physician Executives, Fellow of the American Academy of Pediatrics, Member of the American Medical Association, Certified Healthcare Executive of the American College of Healthcare Executives, and Diplomat of the American Board of Pediatrics.

Dr. Rivera's education includes a Doctor of Medicine, University of Puerto Rico, 1971; and a B.S. in Biology and Chemistry, University of Puerto Rico, 1967.

Robert Washington, Sr.

Mr. Robert Washington, Sr., is the Director of Member Services of the Fleet Reserve Association (FRA). He joined the Association in February 1988 and has been a member ever since.

As Director of Member Services, he works hand-in-hand with the Military Coalition and Congress on healthcare issues involving active duty members, reservists, and military retirees and their family members. Robert also serves as a member of the Military Coalition Healthcare Committee and a member of the Navy and Marine Corps Council.

Mr. Washington is a retired Senior Chief Yeoman. Prior to joining the FRA National Headquarters Staff in 1998, he was the Navy's Senior Enlisted Advisor for the Defense Information Systems Agency in Arlington, Virginia. Mr. Washington's sea assignments include service aboard the USS Strong (DD 758), the USS Mount Whitney (ICC 20), the USS Simon Lake (AS 33), and the USS Coral Sea (CV 43). Mr. Washington's career also included shore assignments in Charleston, South Carolina; Orlando, Florida; and Washington, D.C. He graduated from the Navy Senior Enlisted Academy in October 1992.

ANNEX D
Staff Biographies

CDR Thomas Balestrieri, MSC, USN, is the current Designated Federal Officer for the DoD Healthcare Quality Initiatives Review Panel. Additionally, CDR Balestrieri serves as the Director for Administration for the Optimization & Integration Directorate of the TRICARE Management Activity (TMA). Prior to this assignment, CDR Balestrieri served as Military Assistant to TMA's Executive Director. In past assignments, he has worked on the staff of the Chief of Naval Operations and as Executive Assistant to the Director of the Navy's Medical Service Corps. Before his commissioning in the Navy, CDR Balestrieri earned his bachelor's degree in Social Welfare and his MBA in Healthcare Administration, bringing 12 years of corporate healthcare experience to the Navy. CDR Balestrieri is a Diplomate of the American College of Healthcare Executives.

Col Daniel Cohen, USAF, MC, FS, serves as the current TMA Executive Consultant to the DoD Healthcare Quality Initiatives Review Panel. In addition, Col Cohen is assigned to the TMA as Chief Medical Officer and Director, Clinical Operations Division. Before assuming his current responsibilities, Col Cohen served as Medical Director and Director, Population Health Management Directorate of the TRICARE Mid-Atlantic Region, Portsmouth, Virginia. Col Cohen has served in past assignments as Chief of Medical Staff and Senior Flight Surgeon, 48th Medical Group, Lakenheath, England, and Commander, 39th TACG Air Transportable Hospital, Eastern Turkey. Col Cohen is certified by the American Board of Pediatrics, a fellow of the American Academy of Pediatrics, and a member of the Royal College of Paediatrics and Child Health of the United Kingdom. In addition, he holds an appointment to the faculty of the Uniformed Services University of the Health Sciences.

Col D. E. Casey Jones, MC, USA, is a fellow at the United States Army War College, Carlisle Barracks, Carlisle, Pennsylvania. COL Jones is the former Chief Medical Officer for the TRICARE Management Activity (TMA), Office of the Assistant Secretary of Defense (Health Affairs), a position he held from August 1999 until taking his current position in July 2000. Additionally, during his assignment, COL Jones served as the TMA Executive Consultant to the DoD Healthcare Quality Initiatives Review Panel. COL Jones has held clinical, executive, and academic positions in both civilian and military healthcare. Before his assignment at TRICARE, he was the Deputy Commander of a major Army teaching medical center. COL Jones is also the former Chief of Orthopedic Surgery at Madigan Army Medical Center, Ft. Lewis, Washington. COL Jones is board certified in Orthopedic Surgery and holds a Certificate of Added Qualification in Hand Surgery. COL Jones holds numerous memberships in professional associations, including the American College of Healthcare Executives, the American College of Physician Executives, the American

Academy of Orthopedic Surgeons, and the American Society for Surgery of the Hand.

Lt Col James F. Williamson, USAF, BSC, currently serves as Chief of Clinical Performance Improvement in the Office of the Air Force Surgeon General, a position he has held since October of this year. Prior to that, he was the Deputy Director of Population Health and Clinical Quality for the TMA. While assigned to the TMA, Lt Col Williamson also served as the Designated Federal Officer for the DoD Healthcare Quality Initiatives Review Panel. While assigned, Lt Col Williamson's area of responsibility was quality management, including licensure, accreditation, credentials/privileges, medical readiness, external review, and the National Practitioner Data Bank. Before his assignment at TMA, Lt Col Williamson served as Chief of Optometry Services at Randolph, Wiesbaden, and MacDill Air Force Bases. Lt Col Williamson's degrees include a Doctor of Optometry from the Pennsylvania College of Optometry. He is a fellow of the American Academy of Optometry and a member of the American Optometric Association and the National Association for Healthcare Quality.

ANNEX E
Glossary of Acronyms Used in This Report

AABB	American Association of Blood Banks
AFIP	Armed Forces Institute of Pathology
ASBPO	Armed Services Blood Program Office
BDC	Blood Donor Center
CAP	College of American Pathologists
CBER	Center for Biologics Evaluation and Research
C&CS	Communications & Customer Services (Directorate)
CCQAS	Centralized Credentials Quality Assurance System
CEPRP	Civilian External Peer Review Program
CHCS I	Composite Health Care System, First Implementation
CHCS II	Composite Health Care System, Second Implementation
CLIA	Clinical Laboratory Improvement Act (1967; amended 1988)
CLIP	Clinical Laboratory Improvement Program
COE	Center of Excellence
COLA	Commission on Office Laboratory Accreditation
CPG	Clinical Practice Guidelines
CPR	Computerized Patient Record
DEERS	Defense Enrollment Eligibility Reporting System
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DLM	Department of Legal Medicine
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DOES	DEERS On-Line Eligibility and Enrollment System
DPDB	Defense Practitioner Data Bank
DRG	Diagnosis Related Group
DVA	Department of Veterans Affairs
FDA	Food and Drug Administration
GAO	General Accounting Office
GME	Graduate Medical Education
GMO	General Medical Officer
HCC	Healthcare Consumer Council
HCFA	Health Care Financing Administration
HEDIS	Health-plan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act (1996)
HQIRP	Healthcare Quality Initiatives Review Panel
HPSP	Health Professions Scholarship Program
IG	Inspector General
IOM	Institute of Medicine
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
JCS	Joint Chiefs of Staff
LJWG	Laboratory Joint Working Group
MCO	Managed Care Organization

MCSC	Managed Care Support Contract/ Contractors
MDEIS	Medical Data Executive Information System
MHS	Military Health System
MQAP	Medical Quality Assurance Program
MTF	Military Treatment Facility
NAS	Non-Availability Statement
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NED	National Enrollment Database
NPDB	National Practitioner Data Bank
NQMP	National Quality Management Program
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OCLA	Office of Clinical Laboratory Affairs
ORYX™	JCAHO proprietary product integrating healthcare organization performance measures into the accreditation process
OSC	ORYX™ Steering Committee
PCM	Primary Care Manager
PCMBN	Primary Care Manager by Name
PDTS	Pharmacy Data Transaction Service
PHS	Public Health Service
PKC	Problem Knowledge Coupler
QMR	Quality Management Report
QuIC	Quality Interagency Coordination Task Force
SAP	Scientific Advisory Panel
SGO	Surgeon General's Office
STS	Specialized Treatment Services
TMA	TRICARE Management Activity
TOPS	TRICARE Operations Performance Statement
USTF	Uniformed Services Treatment Facility
VETPRO	Veterans Administration Professional Review Program